Mental Health Transformation State Incentive Grant

COMPREHENSIVE MENTAL HEALTH PLAN—YEAR FOUR UPDATE

September 2009

I. Introduction

As Maryland enters the fifth and final year of the Transformation grant, many projects have been sustained and many more have reached a level of momentum that the state is confident will continue beyond the life of the grant. Emphasis is currently being placed on ensuring the transition of services to individuals and organizations outside the Transformation Office, thereby sustaining MHT SIG efforts.

For many years prior to the grant, Maryland's Children's Cabinet served as a mechanism for interagency collaboration. Maryland also had two system of care grants in Baltimore City and Montgomery County that developed new ways to serve children and adolescents. When the new administration took office in 2007, there were many people working to develop cross-agency services for children and adolescents with mental health needs. Building on these strengths, the Transformation grant helped to harness this momentum and commitment by collecting cross agency data and holding and facilitating multiple forums which brought together a cross section of individuals from stakeholder groups, along with the new leadership teams. This collaboration resulted in the development, in 2008, of an Interagency Strategic plan providing a unified vision for serving children across child-serving agencies in Maryland.

Maryland is lucky to have department secretaries in the child serving agencies who are committed to serve children and adolescents and develop a state-wide system of care. In addition to cross agency data analysis, Transformation was able to provide resources to bring the new directors of child serving agencies together for meetings and carry out rapid and comprehensive studies in areas of interest to the new leaders. This created high levels of trust and cooperation among the varying administrations. As part of this new team building, a cross-agency delegation was sent to a system of care conference soon after the new administration took office. This conference served as a catalyst for creating the current level of collaboration among participating agencies. The result has been rapid systems change in a number of areas discussed throughout the CMHP and it provided Maryland with the foundation to successfully obtain over $30 million in grant funds over the past two years. The will of the agencies and the camaraderie of staff have allowed hurdles to be overcome very rapidly, even in exceptionally tough fiscal times. These early interventions allowed Maryland to leverage resources to create a new vision and harness a sense of hope, making rapid systems change possible.

As time progressed, many agencies were willing to contribute resources toward building a better system for children with mental health needs, which in turn built more momentum, resulting in more resource sharing. Even in the current fiscal climate, Maryland received a CMS PTRF demonstration waiver for wraparound services as well as grants that allow us to focus on children and youth with mental health needs in the child welfare system – work that is carefully targeted to prevention and early intervention, based on current data and the latest research in both disciplines. In addition, Maryland is close to implementing an evidence based practice in Treatment Foster Care. MHA has also begun a study to address increasing concern that children and adolescents, especially those in out-of-home placements, are being over-medicated with psychiatric drugs. The goal is reduce side effects from psychiatric medications and improve

mental health and behavioral health outcomes in children and adolescents under the care of the Department of Human Resources (DHR) and/or the Department of Juvenile Services (DJS).

In the initial years of the grant, the focus was on individual projects. As the lens is pulled back, one can now see how the projects have woven together. The exciting part of the big picture is that as individual projects have been implemented, they have created a synergy that has resulted in greater change than could have been anticipated if each initiative were looked at separately. Together, these projects have had greater impact and accomplished more than they ever could have acting alone. Initiatives such as WRAP, Self-Directed Care, Consumer Quality Teams and the Recovery Project have provided significant incentive to other projects to get better results. Strong leadership of consumers in all four programs has brought Maryland to a significantly higher level of consumer driven services throughout its system, from the level of direct care all the way up to policy development and system change.

The implementation of WRAP was initially intended to be limited to On Our Own's affiliates. As news of the program's effectiveness as a recovery tool spread, many more agencies became interested in receiving training. A number of providers have now been trained in WRAP and many have staff and consumers who are trained WRAP facilitators. Many more providers are scheduling WRAP trainings in the coming year.

With the implementation of recovery regulations and WRAP, providers are now entering the next phase of systems change, becoming Recovery Centers of Excellence. These selected centers will receive intense training and technical assistance which will allow them to serve as mentors to other agencies. In partnership with Transformation and the University of Maryland, On Our Own is taking the lead to develop training for the centers.

The Self Directed Care project is another example of a program that has provided inspiration to others. Self Directed Care has developed models that have taught other projects to look for non-traditional treatment alternatives. The project staff has been able to stretch the budget of the program through creative solutions such as obtaining donated services or services with reduced costs. Program participants are so happy with the available services that they only use those that they really want, resulting in cost savings. The strong leadership skills of the project directors for consumer run initiatives have demonstrated, in a concrete way, the value of having consumers in key positions.

During the final year of the grant it is expected that more projects will have an impact on the system. Maryland will be facing additional budget cuts this Fall and there may be some places where projects are stalled, but the relationships and knowledge gained across disciplines will ensure that the momentum generated by mental health reform efforts will continue to accelerate beyond the grant.

As in previous years, this CMHP submission's initiatives are organized into four categories:

A. Community Outcomes
B. Child Well-Being Outcomes
C. Adult Recovery and Resilience Outcomes
D. Older Adult Recovery and Resilience Outcomes

II. Progress during FY09

A. Community Outcomes

Goal 1: Implement the Mental Health First Aid (MHFA) Program
Goal Overview: Under Community Outcomes Goal 1, the MHT-SIG continues to develop the capacity to respond to individuals experiencing an emerging mental illness or a psychiatric emergency. Trainings continue and the final US adaptation of the adult manual has been completed. Maryland will continue to work with the Missouri MHT-SIG and the National Council for Community Behavioral Health on the development of a youth manual or supplement. The corps of certified Instructors who are regionally distributed throughout the State has expanded to 60 individuals. Since the program's launch in Fall 2008, 73 trainings have been held and 1,183 Marylanders in a variety of settings have been trained. The MHFA Manual and Instructor Teaching Notes have been completed and are now available for sale. More than 6,509 manuals and 326 Instructor Training Kits have been produced and distributed for trainings conducted in Maryland and throughout the United States. Implementation of course fees began in January 2009. Lastly, the National Executive Committee continues to meet regularly to ensure consistent, nationwide implementation of MHFA and to continue collaborative efforts with the program's founders in Australia.

Goal 2: Develop and Implement Network of Care (NOC)
Goal Overview: The Network of Care for Behavioral Health was designed to provide simple and fast access to information for persons with mental illness, caregivers, and service providers. The website provides information about behavioral health services, laws, and related news, as well as communication tools and other features. Under Community Outcomes Goal 2, MHT-SIG continues to utilize the NOC technology to enhance Maryland residents' ability to access consumer driven and recovery oriented information regarding available mental health services. The Maryland Network of Care for Behavioral Health has recorded 294,006 sessions from its May 30, 2008 launch date through August 31, 2009. In response to the increasing numbers of returning veterans, Maryland was the first state in the country to launch the Network of Care for Veterans & Service Members. This site, kicked off by Lieutenant Governor Anthony Brown on March 31, 2009, is a one-stop-shop arrangement, bringing together critical information for all components of the veterans' community, including veterans, family members, active-duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large. Since its March launch through August 31, 2009, the site has recorded 9,544 sessions.

Goal 3: Implement Cultural Competence Initiative
Goal Overview: Providing culturally competent mental health services in Maryland is Goal 3 under Community Outcomes. Maryland is increasingly recognized as a model state for the elimination of health disparities, as is evidenced by its selection as one of six states to participate in the SAMHSA National Policy Summit on the Elimination of Disparities in Mental Health Care. Transformation has taken a two-pronged approach to addressing mental health disparities: (a) helping individuals improve their health status through the promotion of prevention and wellness activities and (b) assisting organizations with the incorporation of cultural and linguistic competence as an integral aspect of their organizational structure and operation.

A number of initiatives have been implemented this year to address disparities. In October 2008, the Mental Hygiene Administration, the Mental Health Transformation Office, and the

University of Maryland's Mental Health Services Training Center co-sponsored MHA's annual Cultural Competence Conference. The one-day conference entitled, "Looking at Evidence-Based Practice and Best Practices: Implications for Cultural and Linguistic Competence," was attended by 130 participants, including consumers, family members, administrators and providers. The second phase of this initiative, assisting organizations, also began this year. The Cultural Competence Committee selected a cultural competency assessment tool and a training program for mental health providers. Once providers were selected, cultural competency analysis was conducted in March 2009. The Institutional Review Board (IRB) process took longer than anticipated, so the project timeline needed to be altered. Pre-assessment surveys began in May 2009 and the first in a series of trainings was held on May 15, 2009. Five additional trainings were held on June 26, July 23, July 30, September 10, and September 11. The training initiative is expected to assist with eliminating mental health disparities by increasing the extent to which the consumers served in these programs demographically and culturally reflect the surrounding community. Lastly, the Maryland legislature passed House Bill 756 (HB 756) establishing a Cultural and Linguistic Health Care Provider Program. The bill encourages health care providers' voluntary participation in educational classes to increase cultural and linguistic competency.

Goal 4: Implement Consumer and Family Driven Social Marketing to support community recovery and resilience

Goal Overview: Under Community Outcomes Goal 4, the MHT SIG continues several social marketing activities that will improve understanding of the principles of recovery and resilience and the role of consumers and family members in implementing systems change. One such activity is the Maryland Mental Health Transformation website which was launched in February 2009. The website provides educational resources and media that support recovery oriented outcomes. Social Marketing consultants have also provided assistance with the launch of both Maryland Network of Care websites, development of brochures and a display board for a consumer smoking cessation project, and the redesign of MHA's FY 2008 Annual Report. The annual report was redesigned to better describe the work of the public mental health system to target audiences, including decision makers, and to highlight consumer and youth voices throughout the publication.

Additionally, the Anti-Stigma Project (ASP) will be evaluated to determine if it is an effective tool for reducing stigmatizing attitudes, beliefs, and behaviors within the mental health system. Measurement tools and criteria have been finalized and instruments have been selected that will evaluate awareness, knowledge, attitude change, and intent to change behavior. The evaluation protocol is currently being reviewed by the IRB at the Illinois Institute of Technology. Once approval is received, the project will begin the IRB process in Maryland. To further highlight issues related to mental health, MHT-SIG co-sponsored the May 2009 Children's Mental Health Awareness Campaign with the Maryland Coalition of Families for Children's Mental Health, the Mental Hygiene Administration, and the Mental Health Association of Maryland. Additional details about the campaign may be found under the Child-Wellbeing Outcomes section, Goal 3. Lastly, through the Maryland Consumer Leadership Coalition (MCLC), Maryland is supporting consumer leaders in their mission to bring the consumer voice to the forefront of effective change. MCLC continues to meet monthly to discuss priorities, map out strategies for action, and convene subcommittees to attain goals. MCLC met with CMS staff members in May 2009 to discuss the parameters regarding Medicaid support for peer support specialists laid down in the August 2007 CMS Letter to State Medicaid Directors.

Goal 5: Utilize State regulatory authority to set forth the expectation of movement toward a community that supports recovery and resilience

Goal Overview: With the promulgation of new recovery regulations completed in January 2008, Maryland is now addressing in-depth program change within community mental health programs through Recovery Centers of Excellence. A Request for Expressions of Interest (REI) for the centers was developed and disseminated. The pre-proposal conference was held on August 11, 2009, with 39 providers in attendance. The deadline for receipt of applications was September 4, 2009. The evaluation committee met on September 18 and 21, 2009. Final decisions were made at the end of September 2009, and implementation activities began October 1, 2009, continuing through September 2010. The Recovery Training Institute (RTI) of On Our Own of Maryland, Inc. has been selected to lead and implement this initiative. In addition, realizing that psychiatrists in the public mental health system may need some specialized information, Transformation funded a recovery training held on March 13, 2009. All community and inpatient facility psychiatrists practicing within the Maryland public mental health system were invited, and 98 attended. Dr. Anita Everett, who originally conceived the conference, served as the master of ceremonies for the event. The keynote address, titled "Recovery from a Psychiatrist's Point of View" was delivered by Ronald J. Diamond, M.D., Department of Psychiatry at the University of Wisconsin. Dr. Diamond's presentation was followed by "What's the Science Behind Recovery?" delivered by Lisa Dixon, M.D., Director, Division of Services Research, the University of Maryland, and "Implementing Services with a Recovery Focus" by Jill Rach Beisel, M.D., Director, Community Psychiatry, the University of Maryland. The training was concluded with a Consumer Panel addressing "What Works Best for Consumers?" facilitated by Clarissa Netter, Director, Office of Consumer Affairs, MHA. Evaluations collected from participants indicated that this training was extremely well-received and it was suggested that this be an annual event

Goal 6: Implement the requirements of legislation (House Bill 281) focused on improving benefits and services for individuals who are incarcerated or institutionalized

Goal Overview: Under Community Outcome Goal 6, the MHT-SIG continues to assist with the implementation of the requirements of HB281, which is aimed at improving inmates' access to mental health services during incarceration and upon release, thereby reducing the cycle of re-incarceration. The Mental Health and Criminal Justice Partnership Committee, which was developed in response to HB 281, meets bi-monthly to address continued collaboration to improve services for individuals with a mental illness who are involved in the criminal justice system. The main focus of this group has now become re-entry. Several initiatives have been implemented to assist individuals with a mental illness as they are released from incarceration. On October 15, 2008, MHA and the Department of Public Safety and Correctional Services (DPSCS) implemented a new process to connect inmates with a mental illness with community mental health services. Inmates are identified prior to release and offered discharge planning. Those inmates who elect to participate receive an appointment with a community provider within four weeks of release. MHA and DPSCS are tracking inmate referrals and provider participation and will report the data to the Maryland Legislature during the 2010 legislative session. To assist with the continuity and coordination of services, on May 7, 2009, DHMH and DPSCS entered into an MOU allowing for data sharing between the two agencies. Additionally, all inmates released from a DPSCS facility receive a 30-day supply of psychiatric medication. Legislation was passed in 2009 to create a Task Force on Prisoner Reentry (HB 637/SB 908). This task force is to look at many reentry issues including funding and best practices for juveniles and adults. Legislation was also passed requiring the Division of Corrections to provide an identification card to inmates prior to their release from a state correctional facility.

The Motor Vehicle Administration will accept this card as a secondary proof of identification and issue a state ID card at no cost to eligible individuals. Additionally, the MVA has begun sending its mobile bus to three DOC facilities each month. The bus can process 50 IDs a month at each location, allowing inmates to obtain their State IDs prior to release. Transformation is working with various stakeholders to better define and coordinate state and local efforts to address the needs of incarcerated individuals with mental health issues. Steps to standardize data collection, establish of a repository of information, and coordinate grant applications are being undertaken so that all efforts relate back to a common vision. MHTSIG is also providing TA assistance on housing in this area, at the request of the committee.

Goal 7: Ensure an adequate, quality, culturally competent mental health system workforce
Because this goal has become closely tied to Adult Goal 4, the two goals have been combined. See Adult section, Goal 4 for details.

Goal 8: Develop centralized capacity for data mining and analysis
Goal Overview: Under Community Outcome Goal 8, Maryland has been transforming its data capability to ensure greater quality and continuity of care. Integrating data systems, consolidating data resources, and gaining access to data from other state agencies that touch the lives of consumers (known as the datamart) assists in tracking trends, establishing an enhanced measurement and reporting system, and improving the capacity to conduct research. On November 10, 2008, the datamart was expanded to include Core Service Agency (CSA) and provider level data. Much progress has been made with change over time analysis in all domains of both the child and adult questionnaire. This data has been made available to the state legislature. An update of change over time analysis was publicly posted in May 2009. The implementation of change over time analysis for CSA level data was completed and reports were mailed out to the CSAs in May 2009. The Award of the RFP for the Administrative Services Organization (ASO) that was originally expected to be awarded in January 2009 was delayed. It was awarded to Value Options in June 2009 and they began providing services September 1, 2009. One requirement of the RFP was the capture of enhanced data collection including federal NOMS and EBPs. Provider level data analysis has begun but with the change in ASO, the details of the datamart, including point in time and change over time analysis, have not yet been addressed.

B. Child Well Being Outcomes

Goal 1: Build infrastructure to support expansion of highly fidelity wraparound services
Objective 1.1: Expand PRTF Waiver to entire state,
Responsible Parties: Maryland Children's Cabinet agencies (Dept. of Human Resources (DHR), Dept. of Budget & Management (DBM), MD State Dept. of Education (MSDE), Dept. of Juvenile Services (DJS), Governors Office for Children (GOC), DHMH/ MHA, Waiver Implementation Workgroup (Staff support from University of Maryland/ Innovations Institute) .
Measurement: # of jurisdictions in which PRTF waiver is operational.
Financing Strategies: Sustained, financed statewide by the waiver with match from Children's Cabinet interagency funds
Action Steps & Timelines: Funds to regional Care Management Entity (CME) contracts will be moved and the new CME providers operating in 3 regions will be transitioned by December 2009. Applicable statutes and regulations will be amended to support and sustain the CME model. Enrollment of youth within the original 4 subdivisions will begin in October 2009.

Enrollment of youth statewide will begin as state match funds become available. Target date for completion of statewide rollout is September 2010.

Objective 1.2: Continue Wraparound and System of Care (SOC) training and coaching to ensure high fidelity.
Responsible Parties: University of Maryland/Innovations Institute (Training, Coaching and Evaluation Staff)).
Measurement: # of providers trained, # of fidelity reports.
Financing Strategies: Sustained.
Action Steps & Timelines: Training, coaching, fidelity data collection and dissemination of semi-annual monitoring reports will continue throughout FY 2010.

Goal 2. Implement Youth MOVE statewide
Objective: Develop Youth MOVE chapters and leadership in each subdivision.
Responsible Parties: University of Maryland/Innovations, Youth MOVE Maryland (Tricia Gurley – State Coordinator), local chapter leadership, MD CARES and RURAL CARES staff
Measurement: # of jurisdictions with a Youth MOVE chapter, # of youth leaders
Financing Strategies: Included in MD CARES and RURAL CARES SOC grant budgets
Action Steps & Timelines: The Youth MOVE statewide coordinator will continue to provide TA to local jurisdictions and recruit local leadership to establish chapters in each of Maryland's 24 subdivisions. Planning activities for the youth-sponsored 2010 Children's Mental Health Awareness Day (held in May 2010) will begin in January 2010. Individual jurisdiction, regional, and statewide meetings will be held throughout the year.

Goal 3: Promote family leadership and involvement in care
Objective 3.1: Increase the number of family members and youth in the mental health workforce.
Responsible Parties: Family Organizations, Care Management Entities (CMEs), and PRTF Waiver Advisory Group
Measurement: # of family members and youth providing family/youth training and peer-to-peer support.
Financing Strategies: Use funds available through new Medicaid PRTF waiver.
Action Steps & Timelines: In October 2009, the statewide family organization and local chapters will complete Medicaid provider applications and enroll as providers for peer to peer support and family/youth training. By January 2010, the family organizations will partner with new regional CMEs to establish working relationships, referral mechanisms, and protocol for involvement in child and family teams. Once application is approved and partnership is in place, the family organizations will begin providing services to children and their families.

Objective 3.2: Plan and implement 2010 "Children's Mental Health Matters!" campaign
Responsible Parties: Mental Hygiene Administration, MD Coalition of Families for Children's Mental Health (Jane Walker), Mental Health Association of MD (Kari Gorkos), Washington County CSA (Ann Pincus), and Social Marketing Workgroup.
Measurement: # of PSA viewers. # of website hits. # of kits distributed.
Financing Strategies: Combine funds from statewide Family Network grant, MD CARES, Mental Health Association of MD, private donations, and RURAL CARES award.
Action Steps & Timelines: Throughout the year, the Social Marketing Workgroup will continue to meet, and conduct outreach and planning. By April 2010, the following steps will be achieved: obtain commitment from spokesperson(s), partner with a production company and TV

networks, provide and film PSAs, hold annual poster contest, select winner, and print and distribute posters. The campaign will be run throughout May 2010. Planning for the 2011 campaign will begin in June 2010.

Goal 4: Employ and retain quality mental health workforce
Objective: Develop and offer trainings and certificate programs based upon identified core competencies.
Responsible Parties: Workforce Steering Committee, Anne Arundel CSA, Maryland Association of Resources for Families and Youth (MARFY), Community College of Baltimore County
Measurement: # of training modules developed, # of people trained.
Financing Strategies: Self-sustaining through tuition and fees.
Action Steps & Timelines: Quarterly Workforce Steering Committee meetings will continue. The web-based modules of the Core Competencies that have been identified and field-tested by the Committee will be launched by the end of January 2010. Monitoring the enrollment and success of certificate trainings will also continue throughout the year.

Goal 5: Build infrastructure to support improved quality mental health care
Objective 5.1: Address the needs of students with emotional disturbance (ED) and their families.
Responsible Parties: Members of ED Steering Committee (Chaired by Jane Walker, Al Zachik, and Carol Ann Heath)
Measurement: # of policy and financing changes.
Financing Strategies: Special education discretionary funds, existing State dollars
Action Steps & Timelines: The ED Steering Committee will no longer meet monthly, but will convene on an ad hoc basis to discuss critical issues related to implementation. By December 2009, the group will develop a whitepaper based upon five critical issues identified and discussed by the ED Steering Committee over the past year. During the 2010 Maryland legislative session, the committee will meet with stakeholder groups and resubmit legislation to replace the use of the term "emotional disturbance." Once completed, the committee will share the whitepaper with the Children's Cabinet and other stakeholders to establish additional partnerships and buy-in to implement recommended strategies.

Objective 5.2: Advance Evidence-Based Practice and Practice-Based Evidence in Treatment Foster Care (TFC).
Responsible Parties: MHA ,University of Maryland/Children's Mental Health Institute Staff support, Blueprint Committee for Children's EBP Subcommittee (Chaired by Al Zachik), Children's Cabinet Agencies.
Measurement: # of programs implementing practice improvement models; # of regulatory changes.
Financing Strategies: Self-sustaining through state general funds and fees.
Action Steps & Timelines: The TFC section of the Child and Adolescent Needs and Strengths (CANS) Level of Intensity evaluation will be completed by November 2009. An ongoing workgroup whose purpose is to develop and support implementation of the project work plan will be organized and facilitated by November 2009. Review and selection of tools to evaluate effectiveness of practice improvement initiatives and define components, indicators, and outcomes of empirically supported TFC will be conducted before January 2010. From January through April 2010 a survey of TFC programs will be conducted, as will the organization and analysis of existing data sources. In May 2010, target outcomes and standards for different populations and TFC models will be defined and integration of outcomes and fidelity tools into

the identified Outcome System will be completed. Maryland TFC practice models will be developed by July 2010. Starting in July 2010, Performance Improvement Plans at the State and program level with an infrastructure for a monitoring feedback loop will be developed. Review and modification of COMAR regulations will also be conducted.

Objective 5.3: Initiate a program that will reduce overuse and side effects from psychiatric medications and improve quality of mental health and behavioral health care of Maryland's children and adolescents in out-of-home placements.
Responsible Parties: MHA, Blueprint Committee (Chaired by Al Zachik), Children's Mental Health Institute (CMHI -Partnership between Maryland Coalition of Families, University of Maryland, and Johns Hopkins University)
Measurement: # of families and clinicians trained; # of clinicians implementing practice improvement.
Financing Strategies: Use data and research to establish policy and best practice reform without additional cost.
Action Steps & Timelines: CMHI will identify opportunities to improve care using available databases, develop and provide targeted education and training for clinicians and families, and provide "prompts" and consultation to providers regarding medications. This project will maximize evidence-based psychosocial treatments and resources by providing technical assistance to providers in partnership with the statewide family network. Outcomes will be monitored using appropriate and available information technology. Institute staff will develop a plan for medication management in Department of Juvenile Services' facilities. All activities will be conducted in FY10.

Goal 6: Establish a System of Care (SOC) for Transition-aged Youth (TAY)
Objective 1.1: Improve service delivery and practice between adult and child mental health service systems to support TAY.
Responsible Parties: TAY Blueprint Committee (includes Child and Adolescent and Adult Services staff at MHA), Ready By 21 Workgroup, Healthy Transitions Initiative (HTI) grant staff (pending hire), Washington and Frederick County CSAs (HTI sites)
Measurement: # of policy and practice changes; # of jurisdictions with TAY SOC.
Financing Strategies: Implement practice improvement in state-funded programs and develop TAY model through HTI grant.
Action Steps & Timelines: Bi-monthly meetings for cross-agency planning and participation through TAY Blueprint Committee. Ready By 21 efforts will continue. Work with state-funded TAY programs to implement evidence-supported Transition to Independence Program (TIP) will also continue. The HTI Grant will be implemented in Washington and Frederick counties to develop a TAY SOC that will be a model for statewide replication.

C. Adult Recovery and Resilience Outcomes

Goal 1: Facilitate adult consumer and family member involvement in policy making, program planning, quality monitoring, and program evaluation activities
Goal Overview: The programs under Adult Recovery and Resilience Outcomes Goal 1 continue to focus on the core issues of recovery and resilience. Many of these projects involve the preparation of consumers and families to participate in meaningful policy change at the system level. Projects include strengthening the peer-operated network based on a wellness and recovery model and the strengthening of consumer and family member roles in overall policy

making and quality monitoring. NAMI-MD has undertaken a number of activities that are strengthening consumer and family involvement. The dissemination of brochures about mental health issues to primary care physicians' offices continues. In February 2009, 16 volunteer consumers completed the NAMI Connections' state-wide training, and in April 2009, 2 NAMI-MD members were sent to St. Louis to be trained as Connections state trainers. Lastly, NAMI-MD began a twelve week Family to Family education program on September 10; it will run through December 17, 2009.

The Consumer Quality Team (CQT) continues to conduct unannounced visits to mental health service providers. In state FY09, the CQT expanded into Prince George's and Cecil Counties. During the year, CQT conducted visits to PRP's in 10 jurisdictions. They also conducted visits to 5 of MHA's psychiatric facilities. The CQT conducted 170 site visits, interviewing 850 consumers. They also conducted 15 feedback meetings. During the year, training curriculum and materials were developed and 150 hours of training was provided to CQT members. CQT staff worked with members of the Transition Aged Youth Committee to assist with the development of a consumer evaluation team for programs serving Transition Aged Youth. Staff members also worked with the University of Maryland's Systems Evaluation Center (SEC) on SEC's evaluation of the CQT program.

In October 2008, On Our Own of Maryland (OOOMD) began a two-year development project funded by the Transformation Office to establish new funding sources for Maryland's consumer network, thereby potentially broadening its funding beyond traditional sources. The following "fundraising readiness" and infrastructure activities have been completed:

1. An MS Access database was created and customized for OOOMD's donors and prospective donors. To date, approximately fifty prospective funders have been identified and are in varying stages of cultivation.
2. Internet technology was developed, allowing website fundraising via credit cards, increasing internet outreach capabilities, and improving communication between OOOMD and its members and affiliates.
3. The Development Director offers free sustainability workshops for all OOO affiliates and intensive technical assistance to selected affiliates as needed. Fundraising technical assistance (TA) has been provided to all OOOMD affiliate Wellness and Recovery Centers via two free fundraising workshops, and onsite intensive TA was provided to one affiliate, Lower Shore Friends.
4. A concept paper was written for Main Street Housing, Inc., OOOMD's subsidiary housing organization.
5. A draft outline of a new OOOMD publication on "Standards of Accountability" has been completed.

During the course of the year, six full applications have been completed requesting a total of $190,000 for OOOMD projects. All of these proposals have been submitted to funders. During this report period, the OOOMD "Case Statement" was completed. A Case Statement (sometimes referred to as a Case for Support) is a persuasive, annotated five- to eight-page document that serves as a basis for most grant applications and other funding appeals. The Case Statement is a central source from which text may be pulled for funding proposals and appeals, and for brochures, website material, reports and other OOOMD documents. The Case Statement is continually updated based on new information and organizational priorities. Progress has been

made in building funder relationships, creating a funding infrastructure, improving the use of technology, and strengthening the fundraising capacity of OOOMD's affiliate network.

On Our Own of Maryland has also hired Dr. Kathy Muscari to conduct evaluations of all of Maryland's consumer run organizations. The evaluation is looking at grant management, fiscal accountability (including ways to strengthen internal controls), board functioning, adequacy and strength of the board, board/staff relationships, adequacy of funding, recommendations for future funding opportunities, and overall general health of each organization. Upon completion of site visits, each organization receives an individualized report. In FY09, evaluation site visits were conducted at 10 On Our Own affiliates and their sub-centers.

Lastly, the Leadership, Advocacy and Empowerment Program (LEAP) held its annual training June 22-25, 2009. Twelve consumers completed the LEAP training. Speakers included Maryland Delegate Shirley Nathan-Pulliam, Shawn Terrell from CMS, and William Hudock from SAMSHA. This was the first time that federal level speakers presented to LEAP. Topics included leadership skills, advocacy communication, history of the consumer movement, how to engage in changing state and federal policy, partnering with lawmakers, CMS funding mechanisms, federally funded Wellness and Recovery Models, and Medicaid 101.

Goal 2: Provide education on health and mental wellness that will allow consumers to attain recovery through a proactive response to triggers and health issues and adaptation of a healthy lifestyle

Goal Overview**:** Under Adult Recovery and Resilience Outcomes Goal 2, the MHT-SIG continues to provide system changes that assist consumers in the recovery process through WRAP, offering self-directed mental health care, reducing the use of seclusion and restraint practices, and examining non-traditional approaches to mental health treatment. Maryland has a reputation as a national leader in the implementation of Wellness Recovery Action Plans (WRAP), a promising practice that assists consumers in developing individualized plans for achieving wellness and recovery. The original concept of WRAP implementation within the state was limited to On Our Own of Maryland, Inc.'s Network Affiliates. The success and momentum of the project far exceeded the original expectations. Due to the emergence of WRAP as an evidence-based best practice and the timeliness of the implementation of On Our Own of Maryland, Inc.'s WRAP Outreach Project for Network Affiliates, a groundswell of requests from across Maryland occurred. In December 2008, a one day Community WRAP conference was facilitated by Steven Pocklington, Executive Director of The Copeland Center for Wellness and Recovery. The Copeland Center, established by Mary Ellen Copeland, promotes personal, organizational, and community wellness and empowerment by shifting the mental health system's focus toward prevention and recovery. Over 260 inpatient and community providers as well as consumers attended this informational session. This conference generated tremendous interest about WRAP in the provider community. In response to the interest, two three-day WRAP trainings for providers were held on February 4 – 6 and February 10 – 12, 2009. A total of 52 providers and consumers participated in the trainings. The trainings were for educational/orientation purposes as well as an opportunity to recruit new facilitators. Three follow-up trainings for existing WRAP facilitators were held this year: January 11 – 12, 2009 (28 facilitators attending), May 12, 2009 (42 facilitators attending) and June 18, 2009 (43 facilitators attending).

The Self Directed Care (SDC) project served 50 consumers in state FY09. The program is currently serving 51 consumers and there are 15 on a waiting list. About 25% of program

participants are enrolled in college courses and they are maintaining A and B averages. One consumer was able to obtain art supplies to resume her painting. Her work is currently on display as part of a local art exhibit and she sold one of her paintings. Five consumers have moved out of addiction housing programs and into their own apartments. The program staff reports that one of the biggest differences made by the program is the considerable gain in consumers' self-esteem/self-confidence as they participate in the SDC program. The Washington County Mental Health Authority continues to provide ongoing oversight of the project, giving final approval for all requests for services. Plans to provide internet availability to SDC consumers have been delayed until November 2009. This program will be evaluated by an economist at the University of Maryland because it appears to hold promise for a Medicaid waiver or demonstration grant from CMS.

Following the decision made in the previous year to concentrate efforts on one adult facility, Springfield Hospital Center, in eliminating the use of seclusion and restraint, there has been considerable progress made in working with that facility to create a center of excellence and a model for other adult state facilities. The Project Coordinator, Dr. Ruth Ann McCormick, continues to attend the monthly Seclusion and Restraint Committee meetings and the bi-monthly meetings of the Six Core Strategies Committee at Springfield. She is also involved with the final development of a HART (High Acuity Resource Team) project to determine the criteria for its utilization prior to calling a "code" in a crisis situation. This team, still in the developmental stage, will discuss and identify patients at high risk for escalating behaviors, and will serve as an early intervention strategy by providing ideas and resources to staff regarding a particular patient in an effort to avoid escalating behaviors.

Dr. McCormick has continued to provide ongoing technical assistance and support at Springfield Hospital Center as well. She conducted assessments of each unit's progress with seclusion and restraint reduction activities and provided feedback to the units and the CEO. Dr. McCormick monitored progress made by this facility by regularly reviewing data and current trends on seclusion and restraint. This was then discussed with the Assistant Director of Performance Improvement and Utilization Management and brought to the Seclusion/Restraint Committee.

When areas of improvement are identified, the Project Coordinator develops training and educational sessions for Springfield staff. In February 2009, Dr. McCormick and a Trauma Survivor delivered a presentation for the Springfield Psychology Department on "Review of Trauma". Approximately 20 psychologists attended. She co-conducted a "Grand Rounds" workshop with a mental health consumer on "Alternatives to the Use of Seclusion and Restraint: The Culture of Recovery" on April 17, 2009 for the staff and administrators at Springfield. Two workshops in areas "Working with forensic patients" and "Working with traumatic brain injured patients" were delivered in September 2009. Dr. McCormick has also continued to provide ongoing support with the state of Maryland's Prevention and Management of Aggressive Behaviors (PMAB) initiative. Lastly, legislation was enacted to increase the rights of individuals with mental disorders in institutional placements. The new law clarifies the rights of individuals in psychiatric facilities, including the right to receive treatment in accordance with a mental health advanced directive and the right to be free from prone restraint.

The evaluation of Project Connections is being conducted by the Johns Hopkins Bloomberg School of Public Health. During the past year, ranking scales were identified, adapted, or created in order to assess depression, anxiety, post-traumatic stress, social support, coping, and other aspects of psychosocial functioning and were tailored to the different populations at the sites. Cross-sectional and

longitudinal data on psychosocial functioning among the populations of interest will inform future programming, and publication of results is anticipated. Additional interviewing strategies were revised over the course of the planning period to accommodate concerns expressed by staff at the sites related to reducing the burden of research on clients and staff. Significant time was spent working with these community sites to achieve complete buy-in and partnership with the sites in this research. After the questionnaires were modified, research staff conducted mock interviews with the site staff and then revised the surveys accordingly. Mock interviews were then conducted again. Questions, scales and methodology were streamlined without compromising the evaluation's effectiveness. Although the time commitment was substantial, and not anticipated, the research team believes that this time was well spent in crafting a research model that is a true reflection of a community partnership that will yield stronger evaluation results. Due to delays with receiving IRB approval, the evaluation was delayed until approval was received in June 2009. The following is a timeline of activities over the past year:

- September-October 2008: Refinement of initial design and first submission to IRB.
- September 2008 – May 2009: Identification, development, and refinement of interview questions and scales related to depression, postpartum depression and anxiety; social support, coping, and post-traumatic stress.
- October 2008- May 2009: continued dialogue and mock interviewing with sites and re-design as needed.
- Identification and interviewing for research assistant position.
- Spring 2009: Identified team of research volunteers, trained them in interviewing.
- February 2009: Second Submission to IRB
- May-June 2009: Final submission of two revised site specific applications to IRB.
- June 2009: IRB approved designs for both sites.
- June-July 2009: Application for and receipt of SAMSHA approved certificate of confidentiality for both sites.
- July-August 2009: Meetings with sites to prepare for interviewing.

Goal 3: Strengthen and support the movement towards adoption of Evidence Based Practices (EBPs) in adult mental health service delivery

Goal Overview: The Mental Hygiene Administration remains a leader in the national movement toward implementation of Evidence Based Practices and recovery oriented practice. MHT-SIG efforts continue to build on work begun prior to the grant, with an emphasis on sustainability and expansion within the PMHS (Public Mental Health System). MHA and Transformation are moving forward with statewide implementation of three EPB models: Supported Employment (SE), Family Psycho-education (FPE), and Assertive Community Treatment (ACT). The development of a new EBP for co-occurring substance abuse disorders and mental illness is also underway.

Thirty-three programs currently have either been trained or are in the process of being trained in SE. Of those programs, 26 are currently implementing EBP SE. Of the remaining 7 programs, 3 are still in development and their intention is to become an EBP SE site; they continue to be offered consultation/technical assistance. The other 4 programs indicated their withdrawal from the EBP project, citing various reasons such as inadequate SE funding, interest in providing other services not consistent with the EBP model, and in one program's case, unreported agency difficulties. Implementing sites report that approximately 1,760 consumers are receiving EBP SE, up from 1,519 in the February 2009. Of the total number of consumers receiving services, 828, or 47% are now employed. This represents a decrease from previous years due to two

factors: 1) programs adding more consumers reduces the percentage employed, and 2) programs are reporting that the economic problems their communities are facing are a key ingredient, noting that finding jobs is much more difficult in the current economy.
For FPE, there are currently 6 programs that have been trained on the EBP, with 5 of those programs conducting groups during this reporting period. One site currently offers three Multi-Family Groups (MFG) for consumers and families. In addition to the bi-monthly technical assistance calls during which resource materials and practical strategies are routinely shared, ongoing consultation continues to the programs, and includes on-site, telephone and email communication. This consultation also frequently includes observations of the Multi-Family Groups in operation. Additionally, the EBP Consultant/Trainer participated in the fidelity monitoring of these sites during the earlier vacancy in one of the MHA fidelity monitor positions. This includes co-conducting the fidelity assessment, meeting with the other monitor to achieve a consensus rating, contributing to the written report with recommendations, and participating in the exit interview with the program, to review strengths and areas for improvement.

FPE implementation activities include:

- Recruitment and outreach strategies and difficult clinical situations that arise during the Multi Family Group are often the focus of the technical assistance calls, creating peer-supervision and informal problem-solving across sites.
- A refresher course was developed for FPE sites for practitioners of the MFGs and their agency supervisors. A full-day training was held on April 16, 2009, with 21 in attendance.
- Discussion began and training was developed on FPE for ACT programs that have readily embraced this EBP as a natural fit with the ACT services – again, taking advantage of the fact that Maryland has the resources of these EBP experts to cross-train programs on multiple EBPs. ACT leadership attended the April 16th training. (Further actions are outlined under the objectives section).

Maryland continues to have 10 ACT teams operating in the state, serving 780 consumers. Nine of those teams have met fidelity, and are able to bill at the enhanced rate available to programs successfully meeting the fidelity threshold established by MHA. The ACT Training Resource Programs (TRPs) (established under a prior SAMHSA EBP grant) continue to demonstrate their competence in quickly training teams under the supervision of the EBP Center's ACT Trainer/Consultant. Evidence of their competence is demonstrated in their receipt of the SAMHSA Science and Service award for 2009. Having agency staff train other agency staff at a similar hierarchical level remains a very effective strategy and this, along with the excellence of the ACT TRPs, accounts for this success. The ACT Consultant/Trainer continues to provide ongoing onsite, phone and email consultation for established sites.

As of August 2009, the number of EBP programs meeting fidelity standards were: ACT – 9; FPE – 5; and SE – 16. The increase in the number of ACT and SE sites meeting fidelity standards since the last report is thought to be due in part to the provision of additional technical assistance in a more structured fashion. This includes the Consultant/Trainer attending "exit" interviews conducted by the fidelity monitors following fidelity assessments, in order to develop a training/technical assistance plan tailored to the needs of each provider site. Utilizing a tool developed by Dartmouth, and modified for Maryland providers, a Fidelity Action Plan is now prepared in concert with providers and clearly spells out methods to achieve fidelity, including

what actions need to be taken, by whom, and by what date. This document appears to be a very successful, more structured approach, and has been widely accepted by providers.

The implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model for Co-Occurring Disorders continues. Activities are underway in 5 Core Service Agencies, and discussion has begun with the Eastern Shore's 9 counties to combine efforts under a CCISC initiative. If these efforts are successful, 13 of the 24 jurisdictions in Maryland will be implementing this model, which is transformative by its very nature in that it brings together all the organizations within a community serving those with mental illness.

Goal 4: Examine employment options and housing services to increase the mental health system workforce and consumer housing choices.

Goal Overview: Under Goal 4, the Transformation Office has been examining various options to address mental health workforce recruitment and retention issues as well as ways to increase consumer employment and housing services. Workforce development, Supported Employment (SE) and increased housing options provide Maryland residents with the opportunity to receive supportive services that are consumer driven, strengths-based and free of stigma. Achieving this goal involves developing a workforce pipeline for mental health providers and expanding peer support, working with the Technical Assistance Collaborative, Inc, (TAC), expansion of the Ticket to Work Program, and assisting the Main Street Housing program with database development.

During FY 2009, the Sar Levitan Center at Johns Hopkins University, in collaboration with MHA, Transformation, Community Behavioral Health Association, the Governor's Workforce Investment Board, local workforce investment boards, two community colleges, other state and local agencies and consumers, focused its work on workforce and workplace development issues. The Levitan team collaborated with a broad range of professionals including representatives from the provider community, professional boards, the workforce system, and higher education (Essex and Anne Arundel Community Colleges). Since October 2008, this workgroup has met on a monthly basis, and the Center has been working with them to drill down to basic issues such as: recruitment, staff training, retention, reciprocity, credentialing, licensing, testing, use of technology, development and linkage to web-pages, and workplace satisfaction.

During this year, the Levitan Center convened 10 workgroup meetings. Two main issues were tackled during this period:

- Improving and strengthening recruitment pipelines for new workers and for refreshing the pipeline. Many of the barriers to effective recruitment in Maryland require legislative and regulatory remedies. Others require revisiting licensing board processes and policies including testing and credentialing. To address these issues, the Levitan Center acted as a liaison, facilitating meetings of workgroup members with former Maryland State Senator Paula Hollinger and administrators and members of the Boards of Social Work, Nursing, Counseling, and Psychology. This work is ongoing, and progress has been made on collaborative practice agreements, regulations promulgated on January 30, 2009, credentialing, testing and licensing, and applications.
- Examining staff development and training policies and practices. Quality, availability and accessibility of current training practices were considered, as well as the need for development of additional training tools such as on-line classes, webinars, and direct training classes. To address training issues, the workgroup agreed to form an

Education/Community College sub-workgroup including representatives of Essex and Anne Arundel Community Colleges, providers, and the workforce system.

A pilot education work study program working towards systems integration involving the community colleges, mental health, and workforce systems has been developed. The pilot will be targeted to new hires at the direct care level and will work towards an AA degree. Two sub-committees have been created to refine logistics and to work on starting dates for both programs no later than mid October, 2009. One sub-committee is led by Essex Community College and the Baltimore County Office of Workforce Development; and the other sub-committee is led by Anne Arundel Community College and the Workforce Development Office for Anne Arundel County. The ultimate goal will be to enhance this work study program leading to an AA Degree.

The Levitan Center has also been exploring the myriad of opportunities for strengthening the participation of consumers in the labor market. An Advisory Group has been convened that will work on a regular basis during the coming year to improve the access of consumers to job markets as they move toward independence and recovery (this is further discussed in section VI).

A housing initiative has been launched with the support and technical assistance of the Technical Assistance Collaborative. In October 2008, TAC submitted a detailed, draft report entitled, "Transforming Housing and Services for People with Serious Mental Illness in Maryland." A revised report was submitted in October 2009. The document includes three major components:

- A complete inventory and analysis of the existing residential program resources available to priority consumers under the auspices of the Department of Health and Mental Hygiene in Maryland
- An inventory of programs in the Maryland Department of Housing and Community Development (DHCD) that serve the needs of mental health consumers, including Low Income Tax Credits, Tenant-Based Programs, the Bridge Subsidy Program and Shelter Plus Care.
- An analysis of the incentives and effects of the current system of residential services and the formulation of recommendations to: (a) improve the consumer-focused recovery outcomes of that system, and (b) explore opportunities to expand access to permanent supportive housing on behalf of priority consumers.

In crafting their report, TAC collected and reviewed numerous documents and statistical reports. They interviewed MHA and housing officials and CSA, PRP and RRP staff as well as designated housing providers, consumer organizations, and hospital liaisons. TAC's analysis found that on average, Maryland rents for one bedroom and efficiency units are much higher than a consumer's entire monthly SSI income. Consumers receiving SSI would need to pay 149.5% of their entire monthly income to rent a one bedroom unit priced at the HUD Fair Market Rent. Efficiency units would cost 131.2% of monthly SSI income. Consumers on SSI are being "priced out" of housing. The report proposed that Maryland use House Bill 231, signed into law by the governor in April 2008, as a platform for a future rental assistance initiative if funding can be identified. Additionally, the TAC report included four specific Recommendations for Action: 1) A Bold Approach: 500 New Units of Tenant-Based Rental Assistance; 2) Improving Outcomes from the Capital Grant Program (DHMH Community Bond Program); 3) Improving Outcomes from DHCD's Disability Set-Aside Policy; and 4) Position MHA/DHCD Relationship for New Section 811 and Trust Fund Legislation.

The Ticket to Work program is a logical next step in the evolution of the Maryland Evidence-Based Practice in Supported Employment initiative. The Ticket to Work program complements the focus on integrated, competitive employment and encourages long-term career development by requiring that supported employment programs assist individuals to achieve significant levels of earnings. The Employment Network (EN) is continuing to rapidly progress in the development of Maryland's Mental Health Employment Network through networking with Maximus (the operations manager for SSA's ticket to work efforts), SSA, Maryland State Department of Education-Division of Rehabilitation Services (MSDE-DORS) and MHA. The MOU between MSDE-DORS and the EN is in the process of development. Ongoing training has been provided to the five pilot supported employment providers through the cooperative efforts of MHA, MSDE-DORS and the EN (Harford County Core Service Agency). Staff of the EN is participating in Ticket to Work internet trainings sponsored by Maximus. Computer hardware has been purchased by the EN to support the data and communication needs of this program. The EN implemented the Ticket to Work program on March 2, 2009, as scheduled. To date, approximately thirty percent of the ticket submissions have been successfully assigned to the Maryland Mental Health Employment Network (MMHEN). Progress meetings with the network are scheduled for the six, twelve and eighteen month points in the pilot program implementation and development. The six month progress meeting was held in August 2009. The newly hired MMHEN Fiscal Manager and MMHEN Program Manager were introduced. The EN is now fully staffed and offering administrative support to the consortium. Morrow Consulting, Inc. is contracted to provide customized software for TTW ticket and payment tracking. Extensive communication and collaboration is continuously occurring between Morrow Consulting and the EN. A preliminary database has been provided and is currently in use by the EN. The MOU between the Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS) and MMHEN has been developed and implemented for a successful flow of data in the partnership. A certified benefits counselor has been made available to provide benefits counseling to all pilot provider staff and ticket-holders starting in the Fall of 2009. Six network meetings and trainings were held from February through August.

Lastly, the Main Street Model (MSM) housing initiative is new to Maryland's CMHP this year. MSM creates housing that is independent from mental health services. It is believed that this is one of the only consumer run housing programs in the country. The MSM espouses the belief that when an individual assumes the responsibilities of tenancy, an enhanced understanding of the mental health services needed to maintain tenancy is the result. Main Street Housing, Inc. (MSH) now operates in 10 Maryland jurisdictions. Working with Transformation, MSH plans to develop a system to track housing outcomes for consumers, including on-time rent and property maintenance for which the tenant is responsible, so that offers of mental health services are connected to the tenancy goals of the consumer. If successful, this system may be of value to other providers of public housing.

Goal 5: Technology to Support Recovery and Resilience

Goal Overview: Transformation is using technology to support recovery and foster information exchange, collaboration and system change. This goal involves specific strategies that are in addition to implementation of the Network of Care (NOC) site, which has already been described previously. Other projects using technology to support the coordination of services include DataLink and Tele-psychiatry. The expansion of the DataLink program to seven additional jurisdictions was delayed waiting for the Office of the Attorney General's (OAG) advice on how to proceed with information sharing between the Department of Health and Mental Hygiene and the medical offices of the local detention centers. Two other factors have also delayed expansion

of the project. The OAG was reviewing the draft Memorandum of Understanding among MHA, Department of Public Safety and Correctional Services, and the local Core service agencies and detention centers. Additionally, an RFP for the ASO contract was delayed. The advice of counsel from the attorney general's office was received on February 9, 2009. This allows for HIPAA compliant information sharing between Medicaid and local departments of corrections. The MOU was amended in light of this new advice and was signed in May 2009. The new ASO contract was awarded in June 2009 and launched in September 2009, so the expansion of the DataLink program to other jurisdictions should be able to proceed once that contract is fully in place.

In November 2008, the Mental Hygiene Administration and the University of Maryland's Department of Psychiatry partnered with three Core Service Agencies (CSAs) to begin providing psychiatric care in seven rural counties in the state. This tele-psychiatry program allows individuals living in rural areas to see a psychiatrist in Baltimore without traveling from their home communities. Clinical services began in December 2008.

Additionally, the Mental Hygiene Administration, the Johns Hopkins University (JHU), and the University of Maryland (UMD) have partnered to develop the Maryland Youth Practice Improvement Committee for Mental Health (MYPIC) to provide video advice to improve mental health care for youth. Video conferencing technology has greatly improved the level of communication among providers. Seven different sites from across the state were able to participate and discuss, in real time, the latest advances regarding medication and treatment. The sites included the Johns Hopkins University, the University of Maryland, Spring Grove Hospital Center, Finan Center, and the three Regional Institutes for Children and Adolescents. Teleconferences began and continue to be held monthly, facilitated by the Directors of the UMD and the JHU Divisions of Child and Adolescent Psychiatry.

Tele-mental health is also being used by Correctional Mental Health Services to provide mental health services in several detention centers and selected state correctional facilities. The use of tele-mental health allows detention centers in rural areas of the state to have more access to psychiatric assessments and evaluations.

The expansion of the Tele-mental health program to Springfield State Hospital Center is underway. Springfield, one of MHA's state psychiatric facilities, has a unit dedicated to serving individuals who are deaf or hard of hearing. A location for the video equipment has been identified on the Deaf Unit. The necessary equipment is being purchased. Once equipment has been installed, staff will be trained and then services can begin.

D. Older Adult Recovery and Resilience Outcomes

Goal 1: Facilitate older adult consumer and their family members' involvement in policy making, program planning, quality monitoring, and program evaluation activities

Goal Overview**:** Under Older Adult Recovery and Resiliency Goal 1, the MHT SIG supports the involvement of older adult consumers and family members in policy making, program planning, quality monitoring, and program evaluation activities. In cooperation with the Maryland Coalition on Mental Health and Aging (a program of the Mental Health Association of Maryland), the project has reached out to family and consumer groups, including NAMI-MD and On Our Own of Maryland, through presentations, trainings, and ongoing communication. The project has also begun to explore how service systems that serve older adults with behavioral

health needs can improve their ability to serve more diverse populations of consumers and families. Transformation's Older Adult Consultant conducted a presentation at On Our Own of Maryland's annual conference in June 2009.

Goal 2: Build an infrastructure that supports the development and implementation of a statewide initiative to improve mental health service delivery systems to older adults and their families.

Goal Overview: Under Older Adult Recovery and Resiliency Goal 2, the MHT SIG continues with the development of an infrastructure that supports a statewide system of care for older adults and their families. The work on assessment, data collection, and research on best practices has been completed. Two Transformation consultants presented their findings from the data analysis and strategies for "aging in place" at the NASMHPD Research Institute's (NRI) Annual State Mental Health Services Research Conference on April 15, 2009.

There have been numerous activities over the past year contributing to system improvements. A joint conference co-sponsored by MHA's Transformation and Adult Services Office and the Maryland Department of Aging was held November 18, 2008. The conference, which was attended by 110 participants from State agencies, CSAs, and Area Agencies on Aging from across Maryland, created a foundation for closer collaboration between the aging and mental health service systems. On May 21, 2009, Transformation was part of a multi-agency summit addressing issues for vulnerable adults. The summit was co-sponsored by DHMH (with MHA, the Alcohol and Drug Abuse Administration, and the Developmental Disabilities Administration represented), the Department of Aging, and the Department of Human Resources. It placed an emphasis on coordination, evidence-based practices and developing more effective strategies for prevention and intervention.

During this year's legislative session, a bill was enacted requiring DHMH to submit a report on the feasibility of creating a coordinated care program to reform the provision of long-term care services under the Medical Assistance program and other State programs in a manner that improves and integrates the care of older adults. The bill was amended to ensure that the mental health services carve-out be preserved in any long-term care reform initiatives that result from this report. Lastly, the Maryland Aging and Mental Health Coalition, housed at the Mental Health Association of Maryland, continues to serve as the steering committee for the Older Adult Initiative.

III. Accomplishments

Identify projected accomplishments you hope to achieve by the end of the grant. Describe:

- How transformation will be experienced in all parts of the state and for all populations;
- How the continuum of care and services will have changed, and what gaps remain;
- How the system is less fragmented in its administration and financing;
- How consumer, family and youth are represented in policy decisions;
- How evidence-based practices throughout a statewide department or service system(s) (e.g., corrections, children's mental health) have become institutionalized; and
- How TSIG has changed and reinforced attitudinal shifts in public perception regarding mental health and help-seeking behavior.

While the Transformation grant builds on Maryland's long history of programmatic innovation, it has also allowed MHA to reexamine and transform its approaches to supporting Marylanders with mental illness. Transformation funding has assisted in further breaking down the barriers that have sometimes existed among various state agencies, community and provider organizations, and consumer and advocacy networks. By the end of the grant, MHA expects to have infused the principles of recovery and resiliency throughout all aspects of the public mental health system and its partners, and developed a coordinated continuum of services and supports that foster consumer independence and their ability to live, work, and fully participate in their communities. As accomplishments from prior years are examined, one can see that many of Maryland's Transformation efforts have had substantial impact on the entire state.

The goals as described in Community Outcomes Section II include broad statewide interventions reaching individuals across the lifespan. Maryland's Transformation Office has knitted together an array of services that improve the overall health of Maryland residents. Many of Transformation's efforts are targeted to increase access, improve treatment outcomes and reduce health disparities. Innovative programming such as Mental Health First Aid and the Network of Care, the adoption of recovery regulations, the implementation of social marketing strategies as well as the passage of cultural competence and criminal justice focused legislation provide the groundwork for a system that is beneficial to the entire population of the state.

Some specific child goals and projects related to statewide impact are highlighted here. As described in the Child Well-Being Section II under Goal 1, statewide care management entity (CME) contracts will soon be in place allowing for the availability of wraparound service delivery for youth at the residential treatment level of care in all Maryland jurisdictions. Funding for the state Medicaid match will come from existing interagency Children's Cabinet dollars. The CME contract and Waiver service rollout will occur over the next year. Once in place, there will be equity across the State with regard to access to community-based services for youth with serious emotional disturbance who meet medical necessity criteria for residential treatment level of care. Developing a fuller continuum of care and access to services for youth with less severe need will continue to be difficult due to State fiscal challenges. However, the role of the CMEs in Maryland is to develop provider and natural support services and networks in response to needs identified in individualized plans of care. Although the interagency funding mechanism for payment of these services is only in place for those children with the most intensive needs who will qualify for the Waiver, as these new community-based services are developed, availability will increase for purchase by individual agencies or families with their own resources or private insurance. While the goal is to continue to shift deep-end public resources to prevention and early intervention, having such services available for purchase may also help prevent youth from progressing to deeper-end care needs.

Other examples of statewide impact include the increased youth and family leadership and participation as set forth above in Section II, under Goals 2 and 3. While partnership with the Statewide Family Network, the Maryland Coalition of Families for Children's Mental Health, predates the MHT SIG (they helped to develop the original MHT SIG application), their involvement has continued to grow and become further institutionalized in the new Medicaid and Mental Hygiene Administration regulations that were promulgated to support the 1915(c) Waiver. As discussed above, these regulations not only include system of care values and Maryland's wraparound service delivery model, but they also establish Family Support Organizations as Medicaid providers and create new Medicaid Waiver services for youth and

caregiver peer-to-peer support and family/youth training (to be provided by family and youth trainers).

Many of the efforts under Adult Recovery and Resilience Outcomes also have statewide impact. The adult priorities have focused on examining the system at key points and using knowledge gained to develop and adapt new approaches. A longer range goal has been to craft meaningful policy change at the system level. Consumer involvement in policy making, program planning, quality monitoring, and program evaluation activities has fostered significant change in the system as a whole as well as the way individuals receive services. All of Maryland's consumer run drop-in centers have been converted to wellness and recovery centers, empowering consumers to reach their maximum potential through advocacy and peer support. The Consumer Quality Teams had plans to expand to all jurisdictions by the end of the fiscal year but because of budget cuts, they were only able to maintain their current sites. Once the fiscal climate improves, they will expand to the remaining jurisdictions. Projects under the adult area such as Project Connections and Self-Directed Care, which are not currently serving all areas of the State, have the potential to be expanded once their efficacy is demonstrated and resources increase.

Initial work done under adult efforts raised awareness that the needs of older adult mental health consumers had become one of growing concern in the state. A Transformation consultant who specializes in mental health services for older adults and their families was recruited to develop more effective services for this population. Historically, Maryland's system of services for vulnerable older adults has been fragmented, with services restricted by eligibility criteria, funding caps, and over-reliance on institutional care as the safety net for populations with cognitive deficits and severe chronic medical conditions. Over the past few years, DHMH, the Maryland Department of Aging and the Maryland Department of Disabilities have collaborated on a number of initiatives to create stronger community-based alternatives, highlighted by Aging and Disability Resource Centers (funded by CMS to provide a single point of entry into long term care services), the Money Follows the Person initiative, designed to transition residents out of nursing homes and related institutions into the community, and evidence-based programs to promote healthy behaviors and chronic disease management. Implementation of efforts under the Older Adults area will result in service strategies for older adults that are locally-based and guided by statewide policy, founded on reliable data and evidence-based practices, delivered by coalitions of service providers who specialize in aging and mental health, and take holistic approaches to the mental health, medical, social, and financial needs of older consumers.

Some of the older models for financing services in the behavioral health system have not always reflected a focus on consumer needs and choices. Consumers report that under older funding mechanisms, they have been told which programs they can attend rather than being offered a selection. Several Transformation projects are addressing ways to implement programs and services that address consumer choice while remaining cost effective. Maryland's Self-Directed Care project and partnership with the Technical Assistance Collaborative on housing are two examples of strategies meeting these criteria. SDC gives consumers a high degree of choice in the services and supports they feel will assist with their recovery. When services and supports fall outside of traditional mental health treatment, consumers report great satisfaction with the assistance they are receiving. Program staff report that most clients had become skeptical of trying to get help from the system and they had low expectations. The SDC program has been able to help people get what they need to achieve recovery. Consumers have expressed strong support for the program, and their satisfaction and views of themselves and their futures has

greatly improved. In another initiative, the work done by TAC brings together data on housing for people with disabilities and points to policy changes that can make a significant difference in the lives of people with disabilities who are already receiving other state services, while also using resources more efficiently. This initiative has the strong support of Cathy Raggio, Maryland Secretary for the Department of Disabilities. The Department of Disabilities is increasingly assuming leadership for cross agency efforts for adults and transition aged youth with disabilities, especially in the areas of employment and housing. Transformation is also just beginning a project, to be completed over the next year, to examine individuals in the public mental health system who utilize services at a high rate. It is believed that improved service outcomes and reduced costs can be achieved through intensive service coordination (this project is further discussed in Section VI). Results from this study are expected to result in changes in the way services are provided to consumers with higher levels of need.

The State of Maryland has one of the strongest consumer, family and advocacy networks in the country. Maryland recognizes that a healthy and vibrant consumer and family advocacy network increases recovery outcomes and support for the public mental health system. Consumers, family members, and advocates play an essential role in the development of policies and programs. A number of Transformation initiatives, including the Maryland Leadership Coalition, the Leadership and Advocacy Empowerment Program, the Recovery Committee, the Key Advocates Committee, Youth MOVE, and the Maryland Aging and Mental Health Coalition, promote consumer, youth, and family participation and input at all levels. Involvement of consumers, youth, and family members is resulting in a shift toward community-based as opposed to institutional care, closer integration of mental health, medical care, and community support systems, and a greater emphasis on consumer education and user friendly information services. This has been a critical factor as decisions have been made about budget cuts in Maryland.

The study, use, and implementation of evidence-based practices (EBPs) and Promising Practices (PPs) in Maryland has been institutionalized through the establishment of the Children's Mental Health Institute, Wellness and Recovery Action Plans (WRAP), Mental Health First Aid (MHFA), Supported Employment (SE) programs, Family Psycho-Educational (FPE) groups, Assertive Community Treatment (ACT) programs, and Co-Occurring Disorders (COD) programs. To enhance Children's Mental Health Institute efforts, Transformation is funding an initiative to address increasing concerned that children and adolescents, especially those in out-of-home placements, are being over-medicated with psychiatric drugs. Current efforts to monitor and manage this problem are neither systematic nor effective. This project will outline steps to be taken to foster rational medication prescribing and monitoring as a way to address public health concerns about increased medication use among youth in out-of-home placement. Another new project that will be completed over the next year is the implementation of a statewide practice improvement effort that will result in the standardization and improved practice of all (private and public) Treatment Foster Care providers in the State of Maryland. Other statewide EBP and PP initiatives such as WRAP and MHFA are being embedded into the public mental health system. Consumers, providers and other partners throughout Maryland have been eager to receive WRAP and MHFA training, with the demand far exceeding original expectations. Additionally, in 2001, MHA established the Evidenced-Based Practices Center which is housed at the University of Maryland. The Center's goal is to distribute research-based information on mental health treatment to stakeholders in Maryland's public mental health system, and to promote adoption and implementation of those practices throughout the State. The center is responsible for monitoring the SE, FPE, ACT, and COD programs as well as

providing technical assistance, consultation and training. The Evidence Based Practice Center has been a key Transformation partner, both in furthering pre-existing EBPs and PPs in conjunction with Transformation and MHA, but also in implementing new initiatives under Transformation, such as new Recovery practices and the EBP for Co-Occurring Disorders.

One of the goals of Transformation is to change the way people perceive mental illness. Numerous surveys indicate that there is widespread misunderstanding of mental health on the part of most Americans. Most are not knowledgeable about the signs of mental illness or the services available to help people with mental illness. Additionally a significant percentage of people with mental illness do not receive the supportive services they need to help them in coping with and recovering from mental illness. In addition, the needs of people with an emerging mental illness are often not address in a timely fashion, sometimes resulting in less than optimal results. There can also be great stigma surrounding a mental health diagnosis and help-seeking behaviors. Over the past four years, the Transformation project has worked to achieve lasting improvements in the way people respond to mental health issues.

In order for recovery to occur, people must have an understanding about mental illness. According to Dr. Patrick Corrigan, there are three main types of stigma: Public Stigma – what the public does to people with mental illness; Self Stigma – what people with mental illness do to themselves; and Label Avoidance – individuals who try to avoid stigma by not seeking treatment. Transformation efforts have been focused on all three areas of stigma. While all of the priorities of the CMHP have advanced the change and reinforcement of attitudinal shifts in public perception regarding mental health and help-seeking behaviors, there are some noteworthy efforts which include Mental Health First Aid, the Anti-Stigma Project, the System of Care Institutes, the child workforce development efforts, the "Children's Mental Health Matters!" campaign, WRAP and Self-Directed Care.

The Mental Health First Aid program has been demonstrated to provide better recognition of mental health problems and reduce the stigma surrounding mental illnesses. MHFA expands the model of traditional first aid, which is almost exclusively focused on somatic illnesses and injuries, to include mental illness. The program capitalizes on the traditional first aid model by training members of the general public to recognize the signs of a mental illness or a mental health crisis and connect people with the supportive services they need. It holds great promise for preventing the exacerbation of mental illness by helping to assure timely intervention. MHFA also increases the general public's knowledge about mental health issues and the likelihood that they would intervene when encountering a person who is having a mental health crisis or struggling with an emerging mental illness.

Stigma has been noted as one of, if not the biggest, impediments to recovery. The Anti-Stigma Project offers workshops that challenge participants to examine the impact of stigma on both their professional and personal lives. For over ten years, anecdotal evidence about the program has provided evidence that public opinions about mental illness are changing for the better. It is anticipated that the evaluation currently being conducted under the Transformation grant will provide stronger scientific evidence of the program's efficacy.

Another program is the Maryland System of Care Training Institutes (SOCTI), an annual, statewide conference that supports the implementation of a coordinated interagency effort to develop a child-family serving system that can better meet the needs of children, youth and families. SOCTI address a broad array of topic areas, reflecting the many different initiatives

currently underway to improve Systems of Care for children, youth and families in Maryland. Recognizing that many of the workers who have the most contact with children and youth often have the least amount of training and education about mental health issues, Child Well-being workforce efforts are changing the way direct care workers are educated about mental health needs. These workforce efforts have become self-sustaining through tuition and fees, and the trainings and certificate programs will continue to reach additional stakeholders. Another project, *Children's Mental Health Matters*, is an annual public awareness campaign designed to raise awareness of children's mental health needs and enhance outreach efforts to families and communities. The 2009 Children's Mental Health Awareness Campaign was extremely successful in bringing attention to children's mental health issues. The 2010 campaign will build upon the success of the 2009 campaign, continuing to grow, and reach out to additional partners in the years to come.

The WRAP training that has been conducted under the Transformation grant has had a tremendous impact on people's attitudes about recovery. As several research studies have found, WRAP is changing consumers' attitudes and beliefs about recovery. To quote a consumer who participated in a Maryland WRAP training, "I don't have to stay depressed; I really have tools to use. I didn't realize just how many tools I already used and now I have a way to organize and access them that was never available before. I believe I can do this…" WRAP training is also changing the way providers think about recovery. "Providers should have long ago embraced principles of psychosocial rehab and the belief that hope is essential. In fact we were sure we had. Then along came WRAP and hope took on a whole new meaning! No other tool levels the playing field for developing a successful relationship with people in our programs. Many tools keep us in the 'teaching' position, WRAP places us level as a co-facilitator of recovery and planning." Lastly, the SDC program has had an impact on the way consumers view themselves and their recovery. Before SDC, one client, Dolores, would only leave her house for doctor's appointments. Now that she is in the program, she is enrolled in college, utilizes public transportation to visit family and friends, and has obtained a computer to do her school work. "I have so much more self-confidence." Her family, friends and therapist have also commented on her positive changes. To sum up her experiences, Dolores said "This stuff you guys do for us is awesome and it impacts our lives so much that you should be really proud. There are people who are impacted every day. I am so grateful for this program. It's changed my life."

The Transformation grant has been instrumental in allowing Maryland to "turbo-charge" change processes already in motion when the grant was awarded and take them to the next level of transformative impact while at the same time developing new and innovative programs that enhance the lives of all Maryland residents.

IV. Barriers to sustainability

While the economic crisis facing the State of Maryland and the country has had a direct impact on public mental health system services and the sustainability plans for some Transformation projects, the overall goal of Transformation – a system that is recovery and resiliency based, consumer driven and responsive to the needs of individuals with mental health issues across the lifespan, will endure. The changes that Transformation has made with regard to people's perceptions about mental health and the possibility of recovery have been institutionalized.

With Maryland facing an estimated $2 billion deficit in the coming fiscal year following $4.3 billion in cuts already taken, resulting budget cuts may have an impact on some Transformation

programs. Existing and anticipated budget shortfalls are creating both crisis and opportunity for State and local agencies and private nonprofit providers. Programs and service systems are facing reductions and budget shortfalls. At the same time, fiscal constraints are forcing agencies to look for new ways to collaborate and to reconfigure their service models.
The economic crisis is compelling service systems to focus on their core missions and service populations and to look for partners in both the private and public sector. There are some Transformation initiatives that will require creative thinking to overcome sustainability issues.

When MHA decided to implement the use of the Network of Care for Behavioral Health, it was anticipated that the costs for maintenance of the site would be incorporated into MHA's annual budget during the final year of the grant. Due to the severity of the budget cuts to the system, MHA was not able to pick up the costs this year. MHA's objective is to incorporate NOC into its budget when the grant ends. The Network of Care for Veterans and Service Members maintenance is being provided by Trilogy at no additional cost to the state, but that agreement may change if funding for the mental health module is no longer available.

While much of the described accomplishments under the Child Well-Being strategies have institutionalized reform through new contracting mechanisms, policies, practices, and regulations that promote system of care values and principles with emphasis on family- and youth-driven care, today's fiscal climate creates uncertainty about the extent to which dollars can be identified to continue to expand wraparound service delivery. Although we have made progress in developing community-based alternatives to residential care, our children's mental health system remains a deep-ended system that needs to continually shift resources to prevention and early intervention. It will be difficult over the next few years to ensure that deep-end "savings" are reinvested to more fully develop our continuum of care instead of being used to cover budget deficits.

One of Maryland's evidence-based practice programs, FPE, has encountered difficulty with implementation and expansion. Two of the six programs (both within the same umbrella organization) have decided to discontinue FPE, citing low reimbursement rates and staff burden of this EBP as the reasons. A special meeting with FPE providers was organized and conducted by MHA and the EBP Center, but at this time, this EBP continues to be a hard sell, which appears to be the case in other states around the country as well. There is a perceived great deal of preparatory work prior to start-up of FPE groups, and despite MHA's incentivizing this with a significant payment to address this issue, providers continue to turn away from this practice, despite the exceedingly positive anecdotal evidence of the outcomes achieved with the consumers and families attending these groups. Possible additional reasons for the difficulty in growing FPE is provider discomfort with running groups, and also possible historical problems in including families in treatment, often due to provider attitudes and assumptions, rather than family willingness to participate. One strategy to address this problem is to begin employing demand-side strategies (see FY10 Objectives in Section VI).

V. Transition and sustainability <u>strategies</u> that will enable the transformation process to continue after grant funding ends

Sustainability for any system transformation is defined not only by its ability to develop financing strategies, but also by its ability to grow grass-roots support, cultivate cultural competence, and grow leadership within consumer, youth, and family partnerships, all of which can be reflected in responsive policy and regulations. When Maryland received the

Transformation grant, leadership developed a methodical strategy for implementation. Transformation selected projects that were ready to be implemented, had a plan for sustainability, and reflected MHA's value set. All projects were selected because they would produce lasting and sustainable changes in Maryland's public mental health system. Initiatives that at first seemed unrelated, have now been knitted together to form a system that is consumer-driven and recovery and resiliency based. Maryland has developed a three pronged approach to sustaining the momentum of Transformation: 1) Projects were staffed with individuals/agencies who could serve as champions beyond the life of the grant; 2) Recovery principles were embedded into every aspect of the mental health system; and 3) Training and technical assistance built the State's knowledge base and available experts. All programs are sustainable through the various mechanisms mentioned in section 6.

The extent of the cutting edge changes in Maryland's mental health system was recognized by NAMI in their 2009 Grading the States Report. Maryland was one of only six states to receive a "B", the highest grade awarded in this year's report and a full grade higher than the previous report. Some of Maryland's sustainable initiatives are highlighted in this section.

Maryland has worked with service providers to develop a recovery oriented system. MHA implemented regulations requiring clinics and psychiatric rehabilitation programs to operate in accordance with recovery principles. These regulations provided motivation for providers to change their practices. MHA made system-wide training available for all providers and is now working to establish Centers of Excellence among leading providers. This project will provide state-of-the-art training and technical assistance, overseen by the Recovery Training Institute of On Our Own of Maryland, to ensure that recovery is optimally supported within these provider organizations. Once trained, the Centers of Excellence will serve as mentors to other organizations throughout the state. It is believed that Maryland's efforts to ensure recovery are among the most comprehensive in the country.

In conjunction with the changes at the provider level, changes were also being made at the consumer level. All of Maryland's consumer drop-in centers have been converted to wellness and recovery centers. This change emphasizes health and mental wellness that will allow consumers to attain recovery through a proactive response to triggers and health issues and the adaptation of a healthy lifestyle. Transformation is also providing individually targeted technical assistance to each center to ensure that they are optimally positioned to provide support for all consumers who seek to achieve wellness and recovery. Recommendations from Dr. Muscari will be implemented to support efforts to reduce health disparities and to achieve better mental health outcomes.

The new emphasis on wellness and recovery allowed for the development of many innovative programs. The Self-Directed Care (SDC) Program was created to place consumers at the center of decision-making that affects them by promoting self-determination, recovery, and personal responsibility. Consumers can set their own recovery and wellness goals utilizing services and supports outside of the traditional mental health system. When the evaluation of SDC is concluded, information may be used to support grant applications and program expansion. Johns Hopkins Bayview Medical Center used the SDC model when it was developing a recent application for primary and behavioral health care integration. Even though the application was not funded, Hopkins will now increase its efforts to include non-traditional mental health supports such as gym memberships and art classes in treatment plans.

Additional programs include Consumer Quality Teams, which were developed to empower individuals who receive services to be partners with providers, policy makers and family members to improve services in the public mental health system and ensure that those services are person centered. Another initiative, WRAP training, was initially targeted solely to consumers. As knowledge about the program grew, WRAP is now seen as a useful tool for providers to implement as they move toward a recovery model. Demand for training continues as providers recognize WRAP groups as an essential tool of recovery.

While the consumer-run Anti-Stigma Project predates Transformation, this is the first opportunity to scientifically evaluate the program's effectiveness in changing people's belief's about mental illness and recovery. Results from the evaluation will allow OOOMD to enhance this dynamic program and continue training across the country. Lastly, the creation of a Development Director position at OOOMD will provide consumer organizations with the ability to raise revenue outside of traditional funding sources, thereby expanding its funding base.

While inter-agency collaboration is not new, the level of cooperation among agencies is at an all-time high. This collaboration is one of reasons that Maryland has been able to bring in over $30 million in grant funds targeting mental health issues over the past two years. Since receiving system of care grants in Montgomery County and Baltimore City several years ago, Maryland has been setting up a state-wide system of care for children. The receipt of two new system of care grants and a transition aged youth grant will build on the momentum of Transformation.

The collaborative support of multiple local and state agencies and stakeholders has made Maryland nationally known for innovations in child and adolescent services. The Governor's Office for Children has provided a mechanism for coordinating and developing effective services across child serving agencies. The Department of Human Resources received partial funding to build on MHA crisis systems to provide crisis stabilization services to prevent disruptions in foster care placements. It is expected that the new system will go statewide when the economy improves. Maryland also embedded two evidenced based practices for children, Functional Family Therapy and Multisystemic Therapy, within its Medicaid regulations.

Maryland's Children's Cabinet has become the collective champion for the continued transformation of our system of care as evidenced by the statewide regional contracts for care management entities (and wraparound service delivery), new Medicaid and Mental Health regulations, and investment into the Innovations Institute and Children's Mental Health Institutes at the University of Maryland. These Institutes will continue to be the hub of policy and fiscal analyses, research, evaluation, training, and technical assistance. While there is no guarantee that every project will be sustained, permanent change within the system has been made that will remain regardless of economic issues.

Many initiatives targeting adults have also been successful in achieving sustainability. Evidenced based practice models such as Assertive Community Treatment, Family Psycho-education, Supported Employment, and Co-Occurring Disorders treatment will be sustained through MHA's use of enhanced rates for providers meeting fidelity standards. Transformation's workforce development initiative has brought together a variety of stakeholders to address recruitment and retention issues within the mental health system. The group will also design a workforce pipeline and training supports that will help consumers become part of the mental health system workforce as they move toward recovery. This initiative will be sustained through blended funding from the Community College System, local

Workforce Investment Boards and training funds from the Maryland Public Mental Health System.

Recognizing the similarity of several issues, Maryland's Older Adult system is utilizing the lessons learned in the child well-being area to create a system of care for the aging population. The Mental Health Aging in Place Task Force is creating a personal/medical program for older consumers in the public mental health system which would become part of Maryland's Medicaid State Plan or be financed by a Medicaid Waiver. This holistic approach addresses the mental health, medical, social, and financial needs of aging consumers.

Even though systems change is constantly occurring, it has been accelerated under Transformation. All of Transformation's initiatives reinforce each other allowing consumers to achieve a level of involvement and empowerment that goes beyond what they would have achieved on a single project. MHA, in conjunction with stakeholders, is creating a coordinated, comprehensive, accessible, culturally competent, and age appropriate system of services and supports for individuals who have psychiatric disorders, promoting resiliency, health, and recovery. The Transformation grant has been the catalyst for significant change in Maryland's public mental health system.

VI. Objectives, measures, responsible parties, activities, financing strategies and timeline during FY 2010 (October 2009-September 2010).

A. Community Outcomes

Goal 1: Implement the Mental Health First Aid (MHFA) Program
Objective: Deliver Mental Health First Aid Trainings
Responsible Parties: Anne Arundel County CSA, Mental Health Association of Maryland (MHAMD) (Linda Raines), MHA (Daryl Plevy), Missouri Transformation Office (Diane McFarland), and National Council for Community Behavioral Healthcare (Linda Rosenberg)
Measurement: # of persons trained in MHFA
Financing Strategies: Self-Sustaining at end of grant through fees, sales of manuals/teaching notes and fundraising. (MHAMD has developed and implemented a price structure for the Maryland MHFA course; MHFA will also receive payment for each MHFA Manual and Instructor Kit distributed).
Action Steps & Timelines: A contractual relationship with all of the trainers is being developed. MHAMD will oversee the development and implementation of the MD MHFA trainers program. MHAMD is planning to conduct 3 regional instructor trainings during FY 2010, which will yield a total of approximately 72 additional instructors. These instructors will in turn train members of the general public. Three editions of the MD MHFA newsletter will be produced and distributed. The National Executive Committee for MHFA-USA will continue to meet regularly. The Committee will develop and execute plans for training, certification, marketing, and sustainability goals. All activities will be completed by September 29, 2010.

Goal 2: Develop and Implement Networks of Care (NOC)
Objective: Provide consumers with direct, online care planning and information sharing capacity outside the traditional care system. These capacities include online sharing of health information and WRAP planning capacities.
Responsible Parties: Anne Arundel County CSA (Frank Sullivan), Trilogy, Daryl Plevy
Measurement: # of persons accessing NOC

Financing Strategies: The NOC for Veterans will be sustained through the Maryland's Commitment to Veterans initiative. Funding strategies for the NOC for Behavioral Health to be determined.
Action Steps & Timelines: The NOC for Behavioral Health and the NOC for Veterans and Service Members have been fully developed and implemented. Routine maintenance and upgrades will be carried out throughout the next year.

Goal 3: Implement Cultural Competence Initiative
Objective 3.1: Implement recommendations of the Cultural Competence Report
Responsible Parties: Mental Hygiene Administration (Iris Reeves and Keisha Tatum), Anne Arundel County CSA (Frank Sullivan, Oscar Morgan and T. Arthur), DHMH Office of Minority Health and Health Disparities (Carlessia Hussein), DHMH Office of Health Workforce, DHMH Health Occupations Boards and Commissions
Measurement: # of recommendations implemented; increase in percentage of organizational changes completed.
Financing Strategies: Long-term support through public and private grant opportunities.
Action Steps & Timelines: Dr. Hussein's office will be engaged in a more collaborative effort regarding an Annual Cultural Competence Summit, as a follow-up to the work of the Maryland delegation at the 2009 National Policy Summit on the Elimination of Disparities in Mental Health Care. The Mental Hygiene Administration Cultural Competence Advisory Group, with the collaboration of Mental Health Transformation Office consultants, consumers, family members and advocacy groups, will be increasing efforts to expand the Annual Fall Cultural Competence Conference. Discussions will continue with the licensing boards to establish a program whereby licensed mental health practitioners can receive CEUs in exchange for mentoring college students enrolled in mental health programs.

Objective 3.2: Develop and implement a Cultural and Linguistic Leadership Academy designed to advance the knowledge, understanding, and improvement of mental health service delivery to a diverse set of cultural, racial, ethnic, and linguistic communities, including individuals with different values, beliefs, and sexual/gender orientations for the purpose of eliminating disparities in the mental health system.
Responsible Parties: Mental Hygiene Administration (Iris Reeves and Keisha Tatum) and Anne Arundel County CSA (Frank Sullivan, Oscar Morgan and T. Arthur)
Measurement: # of individuals trained by the Leadership Academy.
Financing Strategies: At the end of the Transformation grant, there will be a cadre of highly skilled and trained administrators, direct care staff, and consumers who in turn can train others. During the last year of the T-SIG grant, a fee structure will be developed to ensure that there is the capacity to reach out to people or groups in need while simultaneously charging fees to those who can afford to pay.
Action Steps & Timelines: The basic steps of implementation have been completed (e.g., selection of targeted CSAs and providers and adoption of a cultural competency tool, implementation of a cultural competency analysis, administration of pre-assessment surveys to selected CSAs and providers, training of leadership across state, etc.). In the coming year, the impact of the Leadership Academy will be evaluated through a post-training assessment survey. The formal training manual is being edited. Once edits are completed in October 2009, the manual will be distributed to MHA leadership for review and approval. A one day conference, "Eliminating Mental Health Disparities through Community Advocacy and Engagement" will be held October 20, 2009. Invited participants include consumers, family members, mental health administrators and providers, program directors, and representatives of various advocacy groups.

Goal 4: Implement Consumer and Family Driven Social Marketing to Support Community Recovery and Resilience.

Objective 4.1: Sustain social marketing consortium to continue production of educational materials that promote recovery and resilience.

Responsible Parties: Washington County CSA (Rick Rock and Ann Pincus), Anne Arundel County CSA (Pat Vorus), Howard County CSA (Dick Hegner) and Mental Hygiene Administration (Clarissa Netter)

Measurement: # and scope of educational materials produced.

Financing Strategies: DHMH/MHA will assume responsibility within its Information Systems unit for the Transformation website, which will allow for its continuation once the MHT SIG ends.

Action Steps & Timelines: MHT will assure the timeliness and completeness of Transformation website through end of the grant. Steps are being taken to "migrate" the website to MHA and DHMH. Because the work done on MHA's FY08 Annual Report was so well received, Transformation will assist with the development of the FY09 report. In addition to assistance provided to MHA staff, Transformation consultants will provide as needed social marketing support to consumer, family, and advocacy organizations.

Objective 4.2: Evaluate On Our Own's (OOO's) Anti-Stigma Project.

Responsible Parties: On Our Own of Maryland, Inc., Patrick Corrigan—Project Director, Patrick Michaels—Graduate Assistant, Washington County CSA, and PARt (Participatory Action Research team) members (Jennifer Brown, T. Arthur, Clarissa Netter, and Kim MacDonald-Wilson)

Measurement: # of workshops conducted and participants trained, % increase in positive change in public perception

Financing Strategies: Once an evaluation is completed, an evidence-based "seal of approval" will be obtained, facilitating access to a variety of funding sources.

Action Steps & Timelines: The study will commence on October 1, 2009, data collection will end on February 1, 2010, and a preliminary draft of the first report will be completed by August 2010.

Objective 4.3: Develop and evaluate Children's Mental Health Awareness Campaign.
This objective has been combined with Child Well-being Goal 3, Objective 2.

Objective 4.4: Support the Maryland Consumer Leadership Coalition (MCLC) in its efforts to galvanize the consumer voice and further bring it to the forefront of policy making, decision making, and implementation leading to effective change.

Responsible Parties: Mental Hygiene Administration (Clarissa Netter), Howard County CSA (Dick Hegner), and On Our Own of Maryland (Mike Finkle and Jennifer Brown)

Measurement: Increase in # organizational changes.

Financing Strategies: MHA has permanently funded the Office of Consumer Affairs, headed by Clarissa Netter. As part of her job responsibilities, she will continue to chair the MCLC and ensure that the work continues. The MCLC has received several small grants from Maryland foundations to enhance its work. Exploration of grant applications and other fund-raising opportunities will continue.

Action Steps & Timelines: MCLC will continue to meet on a bi-monthly basis, with more meetings held as needed. A strategy for using peer support specialist positions in the PMHS will be developed by early CY 2010. MCLC will be meeting with staff of CMS to discuss licensing requirements for peer support specialist supervisors.

Goal 5: Utilize State regulatory authority to set forth the expectation of movement toward a community that supports recovery and resilience.
Objective 5.1: Promulgate regulations that govern mental health programs operating in Maryland to establish the expectation that programs adopt a philosophical orientation and strategies based on recovery and resilience.
Responsible Parties: Mental Hygiene Administration (Brian Hepburn, Lissa Abrams, and Clarissa Netter)
Measurement: Regulations were changed in 2008.
Financing Strategies: Sustained
Action Steps & Timelines: Completed in FY 2008.

Objective 5.2: Provide training to all providers and selected consumers served by these providers on the concepts of Recovery and Resilience.
Responsible Parties: Mental Hygiene Administration (Lissa Abrams, James Chambers, Carole Frank, and Clarissa Netter), MHT (Daryl Plevy), Howard County CSA (Steve Stahley and Donna Wells), On Our Own of Maryland (Mike Finkle and Jennifer Brown), and University of Maryland Mental Health Services Training Center (Eileen Hansen).
Measurement: # of individuals trained.
Financing Strategies: The training will be completed using existing funds during FY 2010. The 2nd round of trainings will create Centers of Excellence among four selected providers who in turn will serve as trainers and mentors to other providers within the Maryland Public Mental Health System.
Action Steps & Timelines: A 12-month training and technical assistance module for the Centers of Excellence was designed with extensive stakeholder input. The four providers have been selected and training and technical assistance will begin in Fall 2009. The Recovery Implementation Subcommittee will continue to meet frequently as needed to implement this project.

Goal 6: Implement the requirements of H.B. 281 focused on improving benefits and services for individuals who are incarcerated or institutionalized.
Objective: Develop a plan, consistent with the requirements of H.B. 281, to decrease recidivism and provide enhanced mechanisms to prevent consumers from cycling in and out of the criminal justice system.
Responsible Parties: Mental Hygiene Administration (Larry Fitch) and Mental Health Association of Maryland (Lisa Cuozzo); Mental Health and Criminal Justice Partnership committee.
Measurement: # of organizational changes.
Financing Strategies: The Partnership's efforts are sustained within local and state agency budgets. MHA and the Mental Health Association are committed to maintaining staff to support this effort.
Action Steps & Timelines: The Mental Health and Criminal Justice Partnership committee will continue to meet on a bi-monthly basis. The GAINS Center and TAC will be providing technical assistance on housing for individuals involved in the mental health and criminal justice systems. This event will be held November 3, 2009 and it is being supported through funds available to Maryland's TSIG. In addition, experts from the GAINS Center will provide technical assistance in the spring of 2010 to the criminal justice/mental health community on the sequential intercept model and emerging research in the field related to reducing recidivism.

Transformation will continue to work with state and local stakeholders to ensure that the group's common vision is pursued.

Goal 7: Ensure an adequate, quality, culturally competent mental health system workforce. This goal has been combined with Adult Goal 4.

Goal 8: Develop a centralized capacity for data mining and analysis, yielding more coordinated and efficient services to consumers.
Objective: Improve operations and achieve successful outcomes through an Outcome Measurement System (OMS) that links MHA's data systems and shares data among many entities state-wide. Sharing data can enable the state to realize significant benefits and deliver care to individuals in a more coordinated and efficient fashion**.**
Responsible Parties: MHA (Lissa Abrams and Susan Bradley), University of Maryland-Systems Evaluation Center (Howard Goldman and Sandy Sundeen), Baltimore City CSA (Jane Plapinger, Crista Taylor, and Sheba Jeyachandran) and MD ASO (Value Options).
Measurement: number of organizations that regularly obtain and analyze data.
Financing Strategies: OMS is maintained within the budget of the ASO
Action Steps & Timelines: With the new ASO in place and transitioning, provider level analysis will continue and details of the datamart (point in time and change over time analysis) will be addressed over the next year. Another new effort that will be implemented this year is the analysis of cost savings realized through the provision of intensive case management to break the cycle of high cost service utilization. The evaluation will assess the impact of case management and entitlements outreach on utilization of high-end public mental health system services and costs of public mental health system services among a cohort of Medicaid-insured and uninsured individuals with a recent history of high-cost service utilization. The evaluation will assess: 1) within client pre/post changes in service utilization and cost; and 2) comparison between targeted clients and a control group of similar clients. The goals of the intensive mental health case management projects are to reduce number and length of stay of hospitalizations, ER visits and ultimately cost of care; link individuals to ongoing mental health services; and improve treatment/service outcomes for all participating clients. This program has the potential for replication throughout the State.

B. Child Well Being Outcomes

Goal 1: Build infrastructure to support expansion of highly fidelity wraparound services throughout the state.
Objective 1.1: Expand PRTF Waiver to entire state,
Responsible Parties: Maryland Children's Cabinet agencies (Dept. of Human Resources (DHR), Dept. of Budget & Management (DBM), MD State Dept. of Education (MSDE), Dept. of Juvenile Services (DJS), Governors Office for Children (GOC), DHMH/ MHA, Waiver Implementation Workgroup (staff support from University of Maryland/ Innovations Institute) .
Measurement: # of jurisdictions in which PRTF waiver is operational.
Financing Strategies: Sustained, financed statewide by the waiver with match from Children's Cabinet interagency funds
Action Steps & Timelines: Funds to regional Care Management Entity (CME) contracts will be moved and the new CME providers operating in 3 regions will be transitioned by December 2009. Applicable statutes and regulations will be amended to support and sustain the CME model. Enrollment of youth within the original 4 subdivisions will begin in October 2009.

Enrollment of youth statewide will begin as match is available. Target date for completion of statewide rollout is September 2010.

Objective 1.2: Continue Wraparound and System of Care (SOC) training and coaching to ensure high fidelity.
Responsible Parties: University of Maryland/Innovations Institute (Training, Coaching and Evaluation Staff)).
Measurement: # of providers trained; # of fidelity reports.
Financing Strategies: Sustained.
Action Steps & Timelines: Training, coaching, fidelity data collection and dissemination of semi-annual monitoring reports will continue throughout FY 2010.

Goal 2. Implement Youth MOVE statewide
Objective: Develop Youth MOVE chapters and leadership in each subdivision.
Responsible Parties: University of Maryland/Innovations, Youth MOVE Maryland (Tricia Gurley – State Coordinator), local chapter leadership, MD CARES and RURAL CARES staff
Measurement: # of jurisdictions with a Youth MOVE chapter; # of youth leaders
Financing Strategies: Included in MD CARES and RURAL CARES SOC grant budgets
Action Steps & Timelines: The Youth MOVE statewide coordinator will continue to provide TA to local jurisdictions and recruit local leadership to establish chapters in each of Maryland's 24 subdivisions. Planning activities for the youth-sponsored 2010 Children's Mental Health Awareness Day (held in May 2010) will begin in January 2010. Individual jurisdiction, regional, and statewide meetings will be held throughout the year.

Goal 3: Promote family leadership and involvement in care
Objective 3.1: Increase the number of family members and youth in the mental health workforce.
Responsible Parties: Family Organizations, Care Management Entities (CMEs), and PRTF Waiver Advisory Group
Measurement: # of family members and youth providing family/youth training and peer-to-peer support.
Financing Strategies: Use funds available through new Medicaid PRTF waiver.
Action Steps & Timelines: In October 2009, the statewide family organization and local chapters will complete Medicaid provider applications and enroll as providers for peer to peer support and family/youth training. By January 2010, the family organizations will partner with new regional CMEs to establish working relationships, referral mechanisms, and protocol for involvement in child and family teams. Once the applications are approved and the partnerships are in place, the family organizations will begin providing services to children and their families.

Objective 3.2: Plan and implement 2010 "Children's Mental Health Matters!" campaign
Responsible Parties: Mental Hygiene Administration, MD Coalition of Families for Children's Mental Health (Jane Walker), Mental Health Association of MD (Kari Gorkos) and Social Marketing Workgroup.
Measurement: # of PSA viewers; # of website hits; # of kits distributed.
Financing Strategies: Combine funds from statewide Family Network grant, MD CARES, Mental Health Association of MD, private donations, and RURAL CARES award.
Action Steps & Timelines: Throughout the year, the Social Marketing Workgroup will continue to meet, conduct outreach, and planning. By April 2010, the following steps will be achieved: obtain commitment from spokesperson(s), partner with a production company and TV networks,

provide and film PSAs, hold annual poster contest, select winner, and print and distribute posters. The campaign will be run throughout May 2010. Planning for the 2011 campaign will begin in June 2010.

Goal 4: Employ and retain quality child mental health workforce.
Objective: Develop and offer trainings and certificate programs based upon identified core competencies.
Responsible Parties: Workforce Steering Committee, Anne Arundel CSA, Maryland Association of Resources for Families and Youth (MARFY), Community College of Baltimore County
Measurement: # of training modules developed; # of people trained.
Financing Strategies: Sustained through tuition and fees.
Action Steps & Timelines: Quarterly Workforce Steering Committee meetings will continue. The web-based modules of the Core Competencies that have been identified and field-tested by the Committee will be launched by the end of January 2010. Monitoring the enrollment and success of certificate trainings will also continue throughout the year.

Goal 5: Build infrastructure to support improved quality mental health care for children and youth.
Objective 5.1: Address the needs of students with emotional disturbance (ED) and their families.
Responsible Parties: Members of ED Steering Committee (Chaired by Jane Walker, Al Zachik, and Carol Ann Heath).
Measurement: # of policy and financing changes.
Financing Strategies: Special education discretionary funds, existing State dollars.
Action Steps & Timelines: The ED Steering Committee will no longer meet monthly, but will convene on ad hoc basis to discuss critical issues related to implementation. By December 2009, the group will develop a whitepaper based upon five critical issues identified and discussed by the ED Steering Committee over the past year. During the 2010 Maryland legislative session, the committee will meet with stakeholder groups and resubmit legislation to replace the use of the term "emotional disturbance" with a less stigmatizing term. Once completed, the committee will share the whitepaper with Children's Cabinet and other stakeholders to establish additional partnerships and buy-in to implement recommended strategies.

Objective 5.2: Advance Evidence-Based Practice and Practice-Based Evidence in Treatment Foster Care (TFC).
Responsible Parties: MHA, University of Maryland/Children's Mental Health Institute Staff support, Blueprint Committee for Children's EBP Subcommittee (Chaired by Al Zachik), Children's Cabinet Agencies.
Measurement: # of programs implementing practice improvement models; # of regulatory changes.
Financing Strategies: Sustained through state general funds and fees.
Action Steps & Timelines: The TFC section of the Child and Adolescent Needs and Strengths (CANS) Level of Intensity evaluation will be completed by November 2009. An ongoing workgroup whose purpose is to develop and support implementation of the project work plan will be organized and facilitated by November 2009. Review and selection of tools to evaluate effectiveness of practice improvement initiatives and define components, indicators, and outcomes of empirically supported TFC will be conducted before January 2010. From January through April 2010 a survey of TFC programs will be conducted, as will the organization and analysis of existing data sources. In May 2010, target outcomes and standards for different

populations and TFC models will be defined and integration of outcomes and fidelity tools into the identified Outcome System will be completed. Maryland TFC practice models will be developed by July 2010. Starting in July 2010, Performance Improvement Plans at the State and program level with an infrastructure for a monitoring feedback loop will be developed. Review and modification of COMAR regulations will also be conducted.

Objective 5.3: Initiate a program that will reduce overuse and side effects from psychiatric medications and improve quality of mental health and behavioral health care of Maryland's children and adolescents in out-of-home placements.
Responsible Parties: MHA, Blueprint Committee (Chaired by Al Zachik), Children's Mental Health Institute (CMHI -Partnership between Maryland Coalition of Families, University of Maryland, and Johns Hopkins University)
Measurement: # of families and clinicians trained; # of clinicians implementing practice improvement.
Financing Strategies: Use data and research to establish policy and best practice reform without additional cost.
Action Steps & Timelines: CMHI will identify opportunities to improve care using available databases, develop and provide targeted education and training for clinicians and families, and provide "prompts" and consultation to providers regarding medications. This project will maximize evidence-based psychosocial treatments and resources by providing technical assistance to providers in partnership with the statewide family network. Outcomes will be monitored using appropriate and available information technology. Institute staff will develop a plan for medication management in Department of Juvenile Services' facilities. All activities will be conducted in FY10.

Goal 6: Establish a System of Care (SOC) for Transition-aged Youth (TAY).
Objective 1.1: Improve service delivery and practice between adult and child mental health service systems to support TAY.
Responsible Parties: TAY Blueprint Committee (includes Child and Adolescent and Adult Services at MHA), Ready By 21 Workgroup, Healthy Transitions Initiative (HTI) grant staff (pending hire), Washington and Frederick County CSAs (HTI sites)
Measurement: # of policy and practice changes; # of jurisdictions with TAY SOC.
Financing Strategies: Implement practice improvement in state-funded programs and develop TAY model through HTI grant.
Action Steps & Timelines: Bi-monthly meetings for cross-agency planning and participation through TAY Blueprint Committee. Ready by 21 efforts will continue. Work with state-funded TAY programs to implement evidence-supported Transition to Independence Program (TIP) will also continue. The HTI Grant will be implemented in Washington and Frederick counties to develop a TAY SOC that will be a model for statewide replication.

C. Adult Recovery and Resilience Outcomes

Goal 1: Facilitate adult consumer and family member involvement in policy making, program planning, quality monitoring, and program evaluation activities.
Objective 1.1: Develop organizational capacity to conduct outreach to identified under-represented groups, and deliver skills training to involve consumers and families at all levels of MHT SIG planning and policy activities in a way that will be sustainable beyond the grant.
Responsible Parties: MHA (Clarissa Netter), Washington County (Rick Rock), NAMI MD (Lynn Albizo).

Measurement: # of persons trained in service improvements; % of organizational changes.
Financing Strategies: NAMI has committed to sustain these efforts through private fund-raising at the state level.
Action Steps & Timelines: NAMI's Peer to Peer Recovery Education Program will be held Oct. 8-Dec.17, 2009. Two rounds of the Family to Family Education Program are being held Sep. 29-Dec. 15, 2009 and Oct. 5-Dec. 21, 2009. NAMI will contract with consumers, family members, and advocates to participate in the statewide roll-out of this program and develop a strategic plan focused on where mental health resources need to be placed. Dissemination of resource information to medical providers in targeted affiliate areas will be completed by June 2010. By January 2010, 20 additional volunteer consumers will be trained to be Connection facilitators. During the year, Advocacy Empowerment trainees will train other affiliate members on advocacy.

Objective 1.2: Develop and implement a State Hospital discharge interview utilizing peer interviewers and principles of person centered planning for individuals who have been hospitalized long term (more than one year) to determine their wants and needs in the community on discharge.
Responsible Parties: MHA (Lissa Abrams) and Anne Arundel County CSA (Terry Bohrer).
Measurement: # of consumers interviewed; Report completed; Increase in number of facilities using report's findings to conduct person centered discharge planning.
Financing Strategies: N/A
Action Steps & Timelines: Completed and report submitted in FY09. Findings from the report were used as MHA's Eastern Shore Hospital Center converted one of its inpatient units into an Assisted Living Unit. As a result of budget reductions, MHA will be closing a psychiatric facility, Upper Shore Community Mental Health Center (USCMHC). The report is being used to guide discharge planning as USCMHC moves individuals from the hospital into the community.

Objective 1.3: Implementation of Consumer Quality Teams (CQT) throughout Maryland to conduct interviews with consumers receiving public mental health services. The process will strengthen self-advocacy and critical thinking in consumers and enhance the quality of mental health services by addressing individual consumer concerns and resolving them at the level of the provider or the local system.
Responsible Parties: Mental Health Association of Maryland (Linda Raines and Joanne Meekins).
Measurement: # of site visits; # of interviews conducted; # of state facilities and community programs visited.
Financing Strategies: Current sites are supported thorough MHA's budget. Additional sites will be built into the state budget as the economy improves.
Action Steps & Timelines: The CQT will conduct site visits in additional local jurisdictions, state facilities, and community programs. The staff training curriculum will be refined and additional staff will be trained. Teams will conduct site visits and feedback meetings. The CQT will continue to identify, categorize, and track issues for resolution. Publish annual report. All activities to be conducted in FY10.

Objective 1.4: Hire Consumer Development Director to assist Maryland's consumer-run network with accessing additional funds to broaden reach of the consumer network and strengthen sustainability.
Responsible Parties: On Our Own of Maryland (Mike Finkle and Diane Dorlester Shenton), MHA (Clarissa Netter).

Measurement: Director hired. Grant funds awarded to consumer-run network.
Financing Strategies: This project was designed in the beginning to be sustained through fundraising, with Transformation providing start-up costs. Our expectation is that the position will be sustained in the manner originally contemplated.
Action Steps & Timelines: The Director was hired in FY 2009. OOOMD will implement a strategic outreach program to individual prospective contributors (consumers, family members and other supporters) using a combination of electronic communications, mail and face-to-face cultivation. Funds raised will not only sustain the Development Director position, but will also allow OOMD to support new projects and sustain existing ones. A proposal to the Eli Lilly Foundation to revise the 1998 OOOMD Anti-Stigma Project Video has been written and will be submitted in October 2009. As was done in 2009, a concerted effort will be made to increase funding from sponsorships for the OOO Annual Conference in June 2010. The Development Director has set a goal of $5,000 in sponsorship revenue for the 2010 conference, thereby doubling that received in 2009. The homepage of OOO's website will be improved with a compelling case for financial support and other features will be implemented to attract consumers and other supporters to the site. A regular e-newsletter will be developed by December 2009 to establish a strong web presence, share meaningful information with members and other supporters, and to build OOO's constituency and prospect database for annual and special fundraising appeals. The Development Director will continue to focus on funder cultivation and grant writing over the next twelve months. With this variety of fundraising strategies, it is anticipated that the Development Director position will be sustained by the end of the grant and OOOMD's fundraising capacity will be greatly enhanced.

Objective 1.5: Evaluate consumer-run organizations to look at issues such as quality control and grant and fiscal management to ensure continuous improvement.
Responsible Parties: Washington County CSA (Rick Rock), On Our Own of Maryland (Mike Finkle), MHA (Daryl Plevy, Clarissa Netter), Kathy Muscari (OOO consultant).
Measurement: Assessment of operations of consumer-run programs, including efficiency and effectiveness.
Financing Strategies: Funded through September 2010 when the evaluations are to be completed. The recommended changes are being implemented as the evaluations are finalized; over time, the changes will be sustained through the enhanced way of doing business brought about by the recommendations made.
Action Steps & Timelines: Dr. Muscari will conduct site visits and evaluations at: Office of Consumer Affairs (Washington County); On Our Own affiliates (Main Street Housing and Frederick, Charles, Cecil, Carroll, Anne Arundel, Howard, Prince George's, Montgomery, Calvert, and St. Mary's counties; Lower Shore Friends and Silver Spring Drop In Center). All site visits for affiliates will be conducted by May 2010. Site visits for non-affiliated peer support programs SPIN, Martylog, and Our Place will be conducted in August 2010. A final report and evaluation will be submitted in September 2010.

Objective 1.6: Conduct a "Leadership, Advocacy and Empowerment Program" (LEAP) to train consumers to advocate for policy change at a state and federal level, and provide them with education on state and federally funded wellness and recovery models.
Responsible Parties: MHA (Clarissa Netter and Susan Kadis).
Measurement: # of consumers trained.
Financing Strategies: LEAP training is part of the Office of Consumer Affairs' budget. Exploration of grant and other fund-raising opportunities will continue in an effort to expand the number of classes offered.

Action Steps & Timelines: The Office of Consumer Affairs will conduct planning meetings from October 2009 – March 2010 in preparation for LEAP training in April 2010.

Goal 2: Provide education on health and mental wellness that will allow consumers to attain recovery through proactive response to triggers and health issues and the adaptation of a healthy lifestyle.

Objective 2.1: Facilitate the adoption and implementation of WRAP training in the local level provider, consumer peer support and advocacy organizations across Maryland as well as MHA psychiatric facilities.

Responsible Parties: MHA (Clarissa Netter), Washington County CSA (Rick Rock), Baltimore Mental Health Systems (Jane Plapinger), and On Our Own of Maryland (Cheryl Sharp).

Measurement: # of consumers trained in WRAP, # of WRAP facilitators trained, # of programs offering WRAP.

Financing Strategies: The coordinator position is embedded in the MHA budget. However, the program has become so popular that demand far exceeds budgeted capacity to conduct trainings. As a result, the program has begun charging fees to be able to expand capacity and most people requesting the training have willingly paid the fees. To the extent that the fees are beyond the capacity of a particular person or entity requesting training, a reduced rate is negotiated where possible.

Action Steps & Timelines: During the next year, OOO MD will conduct 2 three-day "Introduction to WRAP" classes training at least 50 people. OOO MD will be specifically targeting the smaller CSAs in rural areas for one of these trainings. Additional trainings include a five-day "Facilitator" training of up to 18 people who will then be qualified to conduct "Introduction to WRAP" classes and 2 one-day WRAP Facilitator follow-up classes, for those already trained as facilitators, to hone their skills and knowledge level. Cheryl Sharp, Program Coordinator, will take the Copeland Center's Advanced Training Program to become certified as a trainer of WRAP facilitators. OOO MD will work with Network of Care to produce 3 video segments to inform providers and consumers about WRAP-related topics. Ms. Sharp will develop and maintain a system of quality control standards. Ms. Sharp will also work with OOO's Development Director to identify additional funding sources.

Objective 2.2: Implement Self-Directed Care (SDC) project in Washington County to develop innovative approaches to increase consumers' self-determination, choice, wellness, and recovery through use of individually driven budgets to purchase supports not currently available in the PMHS.

Responsible Parties: MHA (Clarissa Netter), Washington County CSA (Rick Rock), Washington County Office of Consumer Affairs (Ethel Nemcek and Casey Lodgson), and On Our Own of Maryland (Mike Finkle).

Measurement: # of consumer participants and alumni.

Financing Strategies: Transformation is funding an economist at the University of Maryland to conduct a study of this program and results obtained to determine whether this model can be built into the state Medicaid plan and/or if a Demonstration grant or waiver is an option. This will be part of the local evaluation for Maryland's Transformation grant

Action Steps & Timelines: Staff will continue to screen appropriate individuals and serve those on the waiting list as others graduate from the program. Ten current clients are scheduled to graduate by December 2009. Participants are scheduled to receive internet access in November 2009. SDC will continue to train interested consumers to utilize Network of Care. Transformation has contracted with a University of Maryland economist to conduct an economic analysis of the program to assess its cost effectiveness and suitability for a Medicaid waiver.

MHA will explore the possibility of initiating similar programs in other jurisdictions when the budget climate improves.

New Objective 2.3: Implement efforts to reduce the use of seclusion and restraint at Springfield Hospital Center.
Responsible Parties: MHA, University of Maryland EBP Center (Eileen Hansen and Ruth Ann McCormick), Springfield Hospital Center (Paula Langmead).
Measurement: Reduction in utilization rates for seclusion and restraint at Springfield (and ultimately in all MHA adult facilities); increased utilization of alternative strategies to manage escalating behaviors; increased number of persons trained in service improvements.
Financing Strategies: Expansion and full scale implementation, once a model is developed, will be supported within existing facility budgets, to the extent possible.
Action Steps & Timelines: Dr. McCormick will continue on-site training, consultation and technical assistance to all levels of staff at Springfield, including administrators, managers, and direct care staff. She will develop and deliver educational programs aimed at addressing key staff concerns such as providing care for an increasing forensic population, understanding the role of past trauma in current behaviors (two sessions are scheduled for October, 2009), and understanding how to work with individuals with traumatic brain injury. Assessment of progress will be accomplished through regular review of data and current trends at Springfield and in comparing this hospital with state and national data. The Project Coordinator will continue to provide ongoing technical assistance to the public child/adolescent facility Master Trainers as they use the START manual. (This may include providing booster sessions for the Master Trainers as turnover of that population occurs).

Objective 2.4: Evaluate Project Connections, a community outreach program that delivers mental health services for people living in communities with high rates of poverty, violence, and instability to leverage ongoing foundation support; and ultimately facilitate improved models available for replication.
Responsible Parties: Baltimore City CSA (Jane Plapinger), Mental Health Policy Institute for Leadership and Training (MHPILT) (Debbie Agus), and the Johns Hopkins Bloomberg School of Public Health (Tamar Mendelson).
Measurement: Assess psychosocial functioning (including depression, anxiety, PTSD, social support, and coping) at two paradigmatic sites, with a less focused review of the remaining sites.
Financing Strategies: The evaluation will be completed before the end of the MHT SIG, and the results of the evaluation will determine next steps.
Action Steps & Timelines: Groundwork has been laid for the evaluation (PI hired, site meetings held, IRB approval obtained, etc.). Interviewing will commence in the Fall of 2009. Review of baseline and qualitative data will be conducted throughout the evaluation. Data analysis will be conducted by April 2009. Evaluation will be completed by June 2010. Final report will be prepared in September 2010.

Goal 3: Strengthen and support the movement toward adoption of Evidence Based Practices (EBPs) in adult mental health service delivery.
Objective: Achieve statewide implementation of evidence-based practice (EBP) models in Supported Employment (SE), Family Psycho-education (FPE), Assertive Community Treatment (ACT), and Co-Occurring Disorders (COD); and evaluate programs annually to determine eligibility for EBP rates.
Responsible Parties: MHA (James Chambers, Pat Miedusiewski, and Steve Reeder), University of Maryland EBP Center (Eileen Hansen).

Measurement: Increased # of PMHS programs meeting EBP fidelity standards; increased # of programs implementing EBPs.
Financing Strategies: Enhanced EBP rates are included in the MHA budget, as part of the Medicaid fee-for-service system, except for co-occurring disorders. Once the model for co-occurring disorders is further developed, MHA intends to embed it in the fee-for-service system as well,
Action Steps & Timelines: The MHT-SIG efforts in this area are building on work begun prior to the grant, emphasizing sustainability and expansion within the PMHS. The EBP Center will continue to provide technical assistance, training and consultation to those sites implementing EBPs so that the number of programs meeting fidelity standards is increased. The Center will also contribute to a series of articles on EBPs in the NAMI and On Our Own of Maryland newsletters, to enhance knowledge of EBPs among consumers and families, with the expectation that when consumers and family members are better informed of practices that have shown good outcomes, they will be in a better position to request those practices, and encourage agencies to provide them, if they are not already available. The EBP Center will also explore with MHA whether, and how, to "unbundle" the Integrated Dual Diagnosis Treatment (IDDT) toolkit, to assess the potential of using sections of it to improve overall service delivery for COD. With support from the Technical Assistance Collaborative, MHA is also exploring the use and expansion of the evidenced based practice, Permanent Supportive Housing (PSH), to transform housing services for individuals with mental illness.

Goal 4: Examine employment options and housing services to increase the mental health system workforce and consumer housing choices.
Objective 4.1: Develop and implement recovery focused projects addressing the needs of the mental health workforce.
Responsible Parties: MHA (James Chambers, Clarissa Netter and Daryl Plevy), Anne Arundel County CSA (Frank Sullivan), Johns Hopkins' Sar Levitan Center (Marion Pines), Maryland Consumer Leadership Coalition, OOO (Mike Finkle, Elaine Carroll, and Cheryl Sharp), Maryland Community Behavioral Health Association (CBH), Anne Arundel County and Baltimore County Community Colleges and Workforce Investment Boards, Governor's Workforce Investment Board, Maryland behavioral health licensing boards.
Measurement: increase in the number of policy changes; increase in the number of training programs available; number of trainings conducted.
Financing Strategies: N.A.—This initiative will be sustained through blended funding from the Community College System, local Workforce Investment Boards and training funds from the Maryland Public Mental Health System. In addition, Maryland is seeking a Department of Labor grant to further expand the program.
Action Steps & Timelines: Maryland's Transformation Office will be undertaking several initiatives in the coming year to enhance the State's mental health workforce. The Levitan Center will continue their work on workforce/workplace issues in addition to the education work study pilot program with the provider work group. Should the application to the Department of Labor's Employment and Training Administration be funded, statewide expansion of the pilot program will begin, addressing issues of recruitment and retention. The Levitan Center is seeking additional resources to produce workable approaches and/or policy changes that will positively impact the critical labor force issues of the mental health system. They have contacted the assistant secretary of the Maryland Department of Labor, Licensing, and Regulation to request funding assistance. In addition, the Levitan Center will meet with the Consumer Advisory Workgroup that includes representatives from MCLC, OOO MD, CQT, ASO, Prologue Inc, and MHTSIG at least six times this year to develop options for increasing

consumer employment in the mental health workforce. The following goals will be reached by the end of FY 2010: (1) design a peer-to-peer one-stop career center approach, (2) conduct at least one training session related to that approach, and (3) draft a user-friendly language brochure for Maryland consumers based on the New York State model (as time permits). Lastly, the Consumer Advisory Workgroup will sponsor a statewide Employment Summit to explore new employment initiatives for mental health consumers. During the summit, MCLC will have a special session focusing on developing a Peer Support Specialist model in Maryland.

Objective 4.2: Assess current residential services programs for persons with disabilities. Through a partnership between the Technical Assistance Collaborative (TAC), MHA, DHMH, The Maryland Department of Disabilities, Department of Housing and Community Affairs and the Maryland's Mental Health Transformation Office, the assessment will yield recommendations for future improvements and expansion of housing opportunities for priority consumer groups.
Responsible Parties: MHA (Lissa Abrams, Penny Scrivens, and Daryl Plevy), Howard County CSA (Donna Wells), Technical Assistance Collaborative (Ann O'Hara, Steve Day and Lisa Sloane), DHMH Community Bond program (Elizabeth Bernard and George Upperco), DHCA, and DOD.
Measurement: Increased access to housing options; increased number of affordable housing units.
Financing Strategies: There are three main new HUD funding sources currently moving through Congress focused on providing new supported housing options for people with disabilities that may be available in the coming year: new housing choice vouchers targeted to people with disabilities; rent subsidies to become part of the HUD Section 811 program and housing funds targeted to people with very low incomes. The partners in Maryland are discussing various strategies to tap these resources should they become available. In addition, the parties are discussing the potential to change Maryland housing policy to ensure that more housing options are available to people on SSI and SSDI, most of whom are priced out of the Maryland housing market. In addition, when the economy improves (probably after the Transformation grant ends), Maryland intends to seek state funding for additional rent subsidies targeted to people on SSI and SSDI.
Action Steps & Timelines: The TAC housing report will be presented to the mental health community in the Fall of 2009 and the Spring of 2010. The parties will continue to monitor the housing initiatives moving through Congress and as opportunities to seek additional funds become available, will take action to seek those funds at that time. TAC will provide technical assistance to CSAs that have the capacity to work with local Public Housing Authorities (PHA) to enhance Permanent Supportive Housing options utilizing Housing Choice Vouchers.

Objective 4.3: Broaden the scope and scale of the Ticket to Work Program for mental health consumers in Maryland.
Responsible Parties: MHA (Steve Reeder), Harford CSA (Sharon Lipford), Division of Rehabilitation Services (Bob Burns).
Measurement: Increase percent of organizational changes completed; increase in the number of ticket holders.
Financing Strategies: Sustained through Ticket to Work revenue.
Action Steps & Timelines: Harford CSA, the lead CSA for this program, will continue to provide Maximus, the program manager (PM) for SSA, with the requisite information regarding the assignment of Tickets to the Network and the submission of requests for payment to the PM. Progress meetings will be held in February and August 2010. Beginning in the Fall of 2009, a

certified benefits counselor will be available to provide benefits counseling to all pilot provider staff and ticket-holders. The program will integrate the unemployment insurance (UI) earnings records within the ASO's authorization and data system, positioning the network to provide SSA with the necessary wage information without having to track individual ticket holders. This will allow for uniform reporting by the EN supported employment programs to ensure consistent and timely ticket case management. The EN plans to schedule a meeting for October or November 2009 to continue communication, development of project benchmarks and update the project status.

Objective 4.4: Develop project database to track housing outcomes for consumers.
Responsible Parties: On Our Own of Maryland/Main Street Housing (Kenneth Wireman)
Measurement: Tracking of variables for individuals served to include: rental payments, inspections, and maintenance
Financing Strategies: Once developed, database will be maintained by MSH.
Action Steps & Timelines: Over the next year, MSH will implement an information system to track housing outcomes for consumers, including on-time rent payment, property maintenance for which the tenant is responsible, and inspections, so that mental health services are connected to the tenancy goals of the consumer. A technical expert will be recruited to develop and maintain the database. Prospects for replication by other housing authorities will also be explored. MSH will also explore the role of MSH's identified "Residential Intervention Specialists" (RIS) to create a possible housing authority link with direct mental health services that may be stationed within housing authorities. The RIS role at MSH is to work directly with folks who are having problems that relate to long term permanent housing issues that may become lease violations. In essence, the RIS works specifically with consumers to help ensure that they will be good tenants.

Goal 5: Technology to Support Recovery and Resilience
Objective 5.1: Replicate the DataLink program currently operated between the Baltimore City Detention Center and the mental health Administrative Services Organization to facilitate health record sharing for persons newly detained in jails.
Responsible Parties: Baltimore City CSA (Jane Plapinger and Crista Taylor).
Measurement: Increase in number of jurisdictions implementing DataLink.
Financing Strategies: The program will be sustained by the individual jurisdictions.
Action Steps & Timelines: Because of the issues with MOU's as well as the ASO change as discussed in Section 2, the DataLink program was not implemented in FY09 as was expected. Now that the issues appear to be resolved, the identified counties (Charles, Frederick, Harford, Howard, Prince George's, St. Mary's, and Wicomico) may move forward with implementation of the program.

Objective 5.2: Establish Telemedicine for rural areas and underserved groups, such as people who are deaf and hard of hearing.
Responsible Parties: University of Maryland - Department of Psychiatry (Brian Grady); MHA (Lissa Abrams, Daryl Plevy, and Marian Bland); and Mid-Shore CSA (Joe Newell and Holly Ireland).
Measurement: Increase in number of sites utilizing telemedicine; increased access to services.
Financing Strategies: Medicaid reimbursement
Action Steps & Timelines: Once the Telemental Health regulations have been approved by DHMH, they will be published in the Maryland Register for public comment. After comments are received and responded to, the regulations will be promulgated. The project will continue to

provide services to Eastern Shore counties. Once telemedicine equipment is installed at Springfield Hospital's Deaf unit, services will begin for this site. Anticipated start date is December 2009. The TeleMental Health Alliance will continue to convene on a quarterly basis.

D. Older Adults Outcomes

Goal 1. Facilitate older consumers' and their family members' involvement in policymaking, program planning, quality monitoring, and program evaluation activities.
Objective 1.1: Develop organizational capacity to conduct outreach to older adults and their families, and deliver appropriate skills training.
Responsible Parties: Harford County CSA (Sharon Lipford and Jim Macgill), Maryland Aging and Mental Health Coalition (Kim Burton, based at the Mental Health Association of Maryland (MHAMD))
Measurement: # of consumers, advocates, and service providers receiving skills training.
Financing Strategies: Sustained by MHAMD staff.
Action Steps & Timelines: The Coalition will continue to meet bimonthly to review the status of Older Adult initiatives, promote information exchange, and develop training programs. Jim Macgill and Coalition members will provide technical assistance by phone and in person for state and local projects addressing the behavioral health needs of older adults. They will also assist in planning and implementing training programs and conferences that address the needs of older adults. All activities will be ongoing through September 2010.

Objective 1.2: Conduct outreach to consumer and family member groups to educate them about opportunities to influence service systems through participation on State and local advisory and policy making bodies.
Responsible Parties: Harford County CSA (Sharon Lipford and Jim Macgill), NAMI (Lynn Albizo), On Our Own of Maryland (Mike Finkle), and Mental Health Association of Maryland (Kim Burton).
Measurement: # of educational guides distributed to consumers and family members.
Financing Strategies: Coordination between MHAMD, OOOMD, and NAMI to integrate outreach into existing efforts.
Action Steps & Timelines: An educational guide on aging services and systems for older consumers and their family members will be developed in November 2009. Once developed, the guide will be circulated to consumer organizations for comment. A focus group of consumers and family members will be held in March 2010 to review the guide. Following review by stakeholders, the guide will be distributed to advocates, consumers, and families in June 2010.

Objective 1.3: Create aging and mental health learning community of Maryland providers, advocates, consumers, family members, and other key stakeholders.
Responsible Parties: Harford County CSA (Sharon Lipford and Jim Macgill), Mental Health Association of Maryland (Kim Burton) and Mental Health Aging in Place Task Force.
Measurement: # of participants in learning community.
Financing Strategies: MHAMD will use existing technologies such as Listservs, the Coalition blog, social networking sites, and the Network of Care to create and maintain the learning community.
Action Steps & Timelines: The Task Force will expand its contact list of professionals, advocates, and consumers interested in aging and mental health issues, thus expanding the learning community on a monthly basis. Information about research, training, and innovative models will be disseminated to the learning community. The learning community will be used to

develop two customized training sessions on aging and mental health and provide ongoing technical assistance. Activities will continue through September 2010.

Goal 2: Build an infrastructure that supports the development and implementation of a statewide initiative to improve mental health service delivery systems to older adults and their families.

Objective 2.1: Collect data on the current mental health needs of older adults in Maryland by way of partnering with agencies, selecting and formatting information from public databases, and conducting interviews with consumers, advocates, and family members.

Responsible Parties: Harford County CSA (Sharon Lipford and Jim Macgill), MHA (Jim Chambers), Mental Health Association of Maryland (Kim Burton), and Mental Health Aging in Place Task Force.

Measurement: Extent and quality of data collected; number of providers implementing new model.

Financing Strategies: Ultimately, MHA intends to seek funding through the State Medicaid plan or a Medicaid Waiver, but this will probably occur after the Transformation grant ends.

Action Steps & Timelines: With the completion of the data collection project in May 2009, follow-up activities in FY 2010 include identification of high cost jurisdictions for intervention and systems planning development, development of local planning models to improve the integration of somatic and behavioral health, and formulation of recommendations for maintenance of local planning models. A plan for a personal care program targeted to PMHS consumers in group residential settings will be submitted to the Maryland Medicaid program in December 2009. A final plan with a fiscal impact statement will be submitted by June 2010.

Objective 2.2: To improve outreach to PMHS-eligible older adults who are not receiving services.

Responsible Parties: Harford County CSA (Sharon Lipford and Jim Macgill), MHA (Jim Chambers), Mental Health Association of Maryland (Kim Burton), and Mental Health Aging in Place Task Force

Measurement: # of local jurisdictions conducting outreach initiatives by the end of FY 2010.

Financing Strategies: MHA and MHAMD will explore public and private funding options to continue outreach.

Action Steps & Timelines: Based on an analysis of Medicaid data, jurisdictions with eligible consumers but low penetration rates for PMHS services will be identified. In February 2010, Task Force members will meet with key public agencies and managed care organizations in targeted jurisdictions to develop outreach strategies. Technical assistance will be offered throughout the year to targeted jurisdictions as they implement outreach efforts.